Supreme Court, U.S.
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No. 97-156

In The
SUPREME COURT OF THE UNITED STATES

October Term, 1997

RANDON BRAGDON

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED JULY 21, 1997
CERTIORARI GRANTED NOVEMBER 26, 1997

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Order of Supreme Court Granting Petition for Writ of Certiorari as to Questions 1, 2 and 3, dated November 26, 1997 288

RELEVANT DOCKET ENTRIES

DATE PROCEEDINGS

U. S. DISTRICT COURT
DISTRICT OF MAINE
Civil Docket No. 94-CV-273

12/01/94 Complaint filed

04/06/95 Amended complaint by Sidney Abbott

04/11/95 Answer by Randon Bragdon to amended complaint; jury demand

04/24/95 Order granting motion to intervene by USA, granting motion for leave to file amicus curiae brief; USA to file brief on same scheduling order as plaintiff (signed by Judge Morton A. Brody)

04/24/95 Intervenor's complaint by Maine Human Rights Commission against Randon Bragdon

05/10/95 Answer to intervenor, Maine Human Rights complaint by Randon Bragdon; jury demand

09/19/95 Motion by USA for summary judgment on constitutional issues re ADA

09/19/95 Statement of material fact by USA

09/19/95 Motion by Maine Human Rights Commission for summary judgment

09/19/95 Statement of material fact by Maine Human Rights Commission

09/19/95 Motion by Randon Bragdon for summary judgment under the ADA and MHRA

09/19/95 Statement of material fact by Randon Bragdon

09/19/95 Motion by Sidney Abbott for summary judgment

09/19/95 Motion by Sidney Abbott in limine to exclude expert report and testimony of Randon Bragdon

09/20/95 Motion by Randon Bragdon for summary judgment on intervening plaintiff Maine Human Rights Commission's complaint

10/06/95 Response by Randon Bragdon to motion for summary judgment

10/19/95 Reply by USA to response to motion for summary judgment on constitutional issues re ADA

10/19/95 Reply by Sidney Abbott to response to motion for summary judgment

10/19/95 Reply by Randon Bragdon to response to motion for summary judgment

10/20/95 Reply by Maine Human Rights Commission to response to motion for summary judgment

10/20/95 Response by Randon Bragdon to motion in limine to exclude expert report and testimony of Randon Bragdon

10/30/95 Reply by Sidney Abbott to response to motion in limine to exclude expert report and testimony of Randon Bragdon

12/22/95 Memorandum of Decision denying motion for summary judgment on intervening plaintiff Maine Human Rights Commission's complaint, granting motion for summary judgment, denying motion for summary judgment under ADA and on grounds that Congress lacks authority to regulate, denying motion for summary judgment under the ADA and MHRA, granting motion for summary judgment on

constitutional issues re ADA (signed by Judge Morton A. Brody)

02/20/96 Motion by Randon Bragdon to vacate injunction order

03/08/96 Response by USA to motion to vacate injunction order

03/08/96 Response by Sidney Abbott to motion to vacate injunction order

03/08/96 Response by Maine Human Rights Commission to motion to vacate injunction order

03/18/96 Reply by Randon Bragdon to response to motion to vacate injunction order

03/18/96 Second 60(b) motion by Randon Bragdon to vacate/relief from order

04/01/96 Response by Maine Human Rights to motion to vacate/relief from order

04/01/96 Response by Sidney Abbott to motion to vacate/relief from order

04/02/96 Response by USA to motion to vacate/relief from order

04/08/96 Reply by Randon Bragdon to response to motion to vacate/relief from order

04/22/96 Order denying motion to vacate/relief from order, denying motion to stay injunction until and pending appeal, denying motion to vacate injunction order, denying motion for further injunctive relief, denying motion for further injunctive relief (signed by Judge Morton A. Brody)

04/22/96 Judgment for Sidney Abbott against Randon Bragdon signed by Morton A. Brody, U.S. District Judge

05/10/96 Notice of Appeal by Randon Bragdon

FIRST CIRCUIT COURT OF APPEALS
Docket No. 96-1643
Appeal from U. S. District Court for the
District of Maine

06/12/96 Civil case docketed

03/05/97 Judgment: Terminated on the merits after oral hearing; affirmed; written, signed, published

03/19/97 Petition for rehearing and for in banc consideration

04/22/97 Order: by Judge Bailey Aldrich, Judge Bruce M. Selya, Judge Michael Boudin, Judge Norman H. Stahl, Judge Sandra L. Lynch. The petition for rehearing and the suggestion of rehearing en banc is denied. (Chief Judge Torruella, dissenting)

SUPREME COURT OF THE UNITED STATES
Docket No. 97-156
October Term, 1997

07/21/97 Petition for Writ of Certiorari filed

11/26/97 Certiorari Granted as to Questions 1, 2, and 3

AMENDED COMPLAINT AND INJUNCTIVE RELIEF SOUGHT

[U. S. DISTRICT COURT
DISTRICT OF MAINE]

[ABBOTT V. BRAGDON]

[Filed 04/06/95]

[Caption Omitted in Printing]

1. This action is brought pursuant to Title III of the American with Disabilities Act (ADA) and Title 5 Sections 4592 and 4621 of the Maine Human Rights Act (MHRA) against Randon Bragdon, D.M.D. ("Defendant Bragdon") to enjoin Defendant Bragdon's policy and practice of refusing to provide dental treatment and services to persons who are HIV-positive or have AIDS.

2. This Court has jurisdiction over Count I of this action under 42 U.S.C. Section 12188 and 28 U.S.C. Section 1331 and over Count II of this action pursuant to 28 U.S.C. Section 1367.

3. Plaintiff Sidney Abbott ("Ms. Abbott") lives in Brewer, Maine, and is an individual who has tested positive for the Human Immunodeficiency Virus (HIV). Ms. Abbott is, therefore, an individual with a disability within the meaning of the ADA, 42 U.S.C. Section 12102(2), and the MHRA, 5 M.R.S.A. Section 4553(7-A).

4. Defendant Bragdon is a dentist who is licensed to practice in the State of Maine. Defendant Bragdon's dental practice, which offers dental services to the general public, is owned by Defendant Bragdon. Defendant Bragdon is a person who owns and operates the professional office of a health care provider, the operations of which affect commerce. Accordingly, Defendant Bragdon is subject to Title III of the American with Disabilities Act. 42 U.S.C. Section Sections [sic] 12181(7)(F) and 12182. In addition, Defendant Bragdon's dental office is a "place of public accommodation" as defined in

5 M.R.S.A. Section 4553(8).

5. On September 16, 1994, Ms. Abbott sought dental care from Defendant Bragdon. On that date, Ms. Abbott went to Defendant Bragdon's office at 30 Judson Boulevard in Bangor, Maine (the "Office") for a previously scheduled dental appointment.

6. At the Office, Defendant Bragdon's staff asked Ms. Abbott to fill out a medical questionnaire which asked whether Ms. Abbott was HIV-positive or had AIDS. In response to the question, Ms. Abbott answered that she was HIV-positive.

7. Ms. Abbott entered Defendant Bragdon's treatment room. Defendant Bragdon performed a quick dental examination of Ms. Abbot and indicated that she had a cavity that needed to be filled.

8. Defendant Bragdon asked Ms. Abbott if she had any medical conditions.

9. In response to Defendant Bragdon's question, Ms. Abbott told Defendant that she was HIV-positive.

10. Defendant Bragdon refused to provide Ms. Abbott with dental treatment at his Office because of Ms. Abbott's HIV-positive status.

11. Defendant Bragdon has a written policy that he does not provide dental treatment to people with HIV or AIDS. A copy of Defendant Bragdon's policy is attached as Exhibit A to this Complaint.

12. Defendant Bragdon indicated to Ms. Abbott that he would provide dental treatment to Ms. Abbott, including filling her cavity, in a separate and different setting – a hospital surgical operatory. Defendant Bragdon also indicated that Ms. Abbott would have to pay the hospital's fee for the surgical operatory.

13. Upon information and belief, as of September 16, 1994, and the date of this Amended Complaint, Defendant Bragdon

has never had privileges to use the facilities of any hospital nor has he ever applied for such privileges.

14. If Ms. Abbott returns to Defendant Bragdon's office for further dental treatment or services, she will encounter the same discriminatory conduct which she experienced on September 16, 1994. Ms. Abbott would return to Defendant Bragdon's office for routine and regular dental treatment, including cleanings and fillings, if Defendant Bragdon offered dental services to HIV-positive persons on the same terms and conditions as he offers dental services to persons who are not HIV-positive.

COUNT I: VIOLATION OF TITLE III OF AMERICANS WITH DISABILITIES ACT

15. Ms. Abbott repeats the allegations contained n Paragraphs 1-14 of this Amended Complaint and incorporates them herein.

16. By denying Ms. Abbott dental treatment in his Office because of her HIV-positive status, and by adopting and implementing a policy of refusal to treat persons who have tested positive for HIV, Defendant Bragdon unlawfully discriminated against Ms. Abbott and has violated Title III of the ADA, including without limitation in the following ways:

A. Defendant Bragdon has denied to Ms. Abbott the opportunity to benefit from the services of a place of public accommodation, in violation of 42 U.S.C. Section 12182(b)(1)(A)(i).

B. Defendant Bragdon has imposed eligibility criteria, for the privilege or advantage or receiving dental services, that screen out the class of persons who have tested positive for HIV, in violation of 42 U.S.C. Section 12182(b)(2)(A)(i).

C. Defendant Bragdon has failed to make reasonable modifications in policies, practices or procedures where such modification is necessary to afford equal advantages or privileges to the class of persons who have tested positive for HIV, in violation of 42 U.S.C. Section 12182(b)(2)(A)(ii).

D. Defendant Bragdon has a practice and policy which provides different and separate dental treatment to individuals who are HIV-positive in violation of 42 U.S.C. Section 12182(b)(1)(A)(iii).

E. By refusing to provide dental services in his Office to HIV-positive individuals, Defendant Bragdon has failed to provide the goods, services, facilities and advantages of a place of public accommodation in the most integrated setting appropriate to the needs of HIV-positive persons, in violation of 42 U.S.C. Section 12182(b)(1)(B).

COUNT II: VIOLATION OF MAINE HUMAN RIGHTS ACT

17. Ms. Abbott repeats the allegations contained in Paragraphs 1-16 of this Amended Complaint and incorporates them herein.

18. On September 21, 1994, Ms. Abbott filed a Complaint with the Maine Human Rights Commission (the "Commission") which alleged that she was denied dental treatment by Defendant Bragdon in a place of public accommodation because she is HIV-positive in violation of the MHRA.

19. By letter dated February 17, 1995, the Commission informed Ms. Abbott and Defendant Bragdon that it had determined that there are reasonable grounds to believe that unlawful discrimination under the MHRA had occurred. The Commission has failed in its efforts to enter into a conciliation agreement with Ms. Abbott and Defendant Bragdon.

20. By denying Ms. Abbott dental treatment because she is HIV-positive, establishing eligibility criteria for treatment which screen out persons with HIV or AIDS, and by providing different, separate and unequal dental services to individuals who are HIV-positive, Defendant Bragdon has violated 5 M.R.S.A. Section 4591 and 4592.

REQUEST FOR RELIEF

WHEREFORE Plaintiff Sidney Abbott requests that the Court:

A. Declare that the discriminatory practices of Defendant Bragdon, as set forth above, discriminate against persons who have tested positive for HIV, in violation of Title III of the Americans with Disabilities Act and Title 5 of the Maine Human Rights Act;

B. Enjoin Defendant Bragdon, his agents and employees, and all other persons in active concert or participation with any of them, from refusing to provide treatment to persons who have tested positive for HIV on the same terms and conditions as patients who have not tested positive for HIV;

C. Order that Defendant Bragdon post a sign in a conspicuous location in his office visible to all patients who enter his office for treatment that: "Randon Bragdon, D.M.D. does not discriminate against persons who have tested positive for the Human Immunodeficiency Virus (HIV) or who have AIDS. Randon Bragdon, D.M.D. provides dental treatment and services to people with HIV or AIDS on the same terms and conditions as are provided to patients who are not HIV-positive;"

D. Award Ms. Abbott her attorneys' fees and costs, including expert witness fees and costs;

E. Award Ms. Abbott civil penal damages in the amount of $10,000 in accordance with 5 M.R.S.A. Section 4613(2)(B)(7); and

F. Order such other appropriate relief as the interests of justice may require.

/s/ Bennett H. Klein, Esq.
/s/ David G. Webbert, Esq.

DEPOSITION OF SIDNEY ABBOTT
DATED MAY 16, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption omitted in printing]

***

[Page 14]

Q. As I understand it, you're HIV positive; is that right:

A. Yes.

Q. Do you distinguish that term describing your condition from suffering from AIDS?

A. I don't have AIDS.

Q. You're just HIV positive?

A. Correct.

Q. And how long have you known you were HIV positive?

A. Nine years.

Q. And has there been any change in your condition during that nine years?

A. No.

Q. And has there been any change or ever any suggestion that you weren't HIV positive during that ten years – nine or ten years?

A. No.

Q. Are you presently under the care of some physician or group or health care provider for this condition?

A. Yes, Dr. Rob Pinsky.

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Q. Did you say Rod?

A. Rob. R-o-b.

Q. What kind of a doctor is Dr. Pinsky?

A. I believe he's an immunologist.

Q. And where is he located?

A. At Eastern Maine Medical Center.

Q. And are you under the care of anybody else for the condition of being HIV positive except for Dr. Pinsky?

A. No.

Q. How often do you see Dr. Pinsky?

A. Every six months.

Q. So you've seen him 15 or 18 times over the last nine years?

A. Yeah.

Q. Has he been your health care provider –

A. Oh, no. no. I've seen him --. I've had other care providers. I had Dr. Jeff Milliken before that.

Q. Where is he located?

A. Blue Hill.

Q. How far back does Dr. Pinsky's treatment go?

A. I believe it's been two years.

Q. And for how – Dr. Milliken was immediately before him?

A. Correct.

Q. And for how long did Dr. Milliken treat you?

A. About two years.

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Q. Why did you change?

MR. WEBBERT: I'm going to object to any questions that go into her medical history, besides the doctors involved, because of her right of privacy in that area.

I'm going to object on the grounds of privilege to any details of her medical treatment other than the fact that she's HIV positive.

***

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MR. GILBERT: I take it it's your position that by bringing this suit, she has not put her medical condition in issue?

MR. WEBBERT: She's put her HIV status in issue, but not anything else.

And as I understand it, it's undisputed that the defendant has a blanket policy of not treating anyone who's HIV positive, regardless of any other details about the nature of the condition.

So not only does she have a privilege, but it's irrelevant to the case, which I think makes it even more obvious that there should be no question on the subject matter.

***

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MR. GILBERT: Just so we're clear on this, you're taking the position that we're not entitled to inquire or obtain discovery that confirms her now sworn assertion that she's HIV positive, but has not progressed to full-blown AIDS?

MR. WEBBERT: We think the issue of whether she's HIV

[Page 19]

positive, she's provided information on that to verify that. But other than that, her medical condition is not in controversy in this case.

MR. MCCARTHY: We disagree.

MR. WEBBERT: Sure.

MR. MCCARTHY: Is there something –

MR. WEBBERT: I'm just telling you I'm going to instruct her not to answer. If that helps move along the deposition, I just wanted to tell you now instead of making it seem confusing to you as to why I was instructing her not to answer.

BY MR. MCCARTHY:

Q. Is there something unusual in your medical background?

A. My lawyer has asked me not to answer anything about my medical background.

***

[Page 24]

Q. Is there a prognosis --. Have you been given a prognosis for your condition of being HIV positive?

MR. WEBBERT: Same objection.

MR. GILBERT: That calls for a yes or no answer.

MR. WEBBERT: Objection, and I instruct you not to answer.

BY MR. MCCARTHY:

Q. As a result of being – or strike that.

Are you impaired in your ability to carry out any of your life functions by the fact that you are HIV positive?

A. No.

Q. And are you impaired in carrying out any of the ordinary functions of life and your life functions by any other condition other than being HIV positive?

A. No.

***

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EXAMINATION

BY MR. WEBBERT:

Q. I have a couple questions. How, if at all, has your HIV status affected your life activity with respect to getting pregnant?

A. I have made the decision after I tested positive not to have children because of the risk of infecting the child and the risk of impairing my own immune system, and also the fact that this baby probably wouldn't have a mother after a while.

Q. How, if at all, has your HIV positive status affected your life activities with respect to seeking employment in the educational field?

A. I made a decision not to seek employment in the

education field because of the stress level involved with teaching. And I chose to remain in my current line of work because it's not as stressful as teaching.

MR. WEBBERT: That's all I have. Any other questions?

MR. CARNES: The Commission has no questions.

MR. McCARTHY: Let me just think for a minute.

MR. WEBBERT: Sure.

MR. McCARTHY: No, I don't have any questions.

***

DEPOSITION OF RANDON BRAGDON, D.M.D.
TAKEN ON JUNE 5, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption Omitted in Printing]

(Page 3)

BY MR. BENNETT KLEIN:

Q. Could you please state your full name for the record?
A. Randon Alvin Bragdon.
Q. Have you ever been deposed before?

(Page 4)

A. Yes, I have.
Q. How many times?
A. Three times.
Q. Would you identify those three times that you have been deposed?
A. The two times that you have deposed me previously and one time involving a timber theft case.
Q. Can you indicate the last deposition?
A. It was a case involved timber theft.

MR. McCARTHY: Timber.

BY MR. KLEIN:

Q. Were you a party to the case of timber theft?
A. Yes.
Q. And were you the plaintiff?
A. No.
Q. What was the plaintiff's name?
A. Mylon Davis.
Q. And I take it you were the defendant in the case?
A. Yes.
Q. When was the case – in what court was the case filed?
A. In, I think Superior Court here.
Q. In Penobscot County?
A. Yes.

Q. Do you know what year the case was filed in?

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A. I would tell them my policy. If they wanted to be treated, I would treat them in the hospital operatory.
Q. Where would you treat them?
A. That is a question now because originally I had thought last year that Eastern Maine still had an adequate facility; but they have since – as I understand it now, they have allowed that to deteriorate and it is not adequate.
Q. Assuming that a patient with infectious hepatitis B presented at your office with an avulsed tooth that needed to be reimplanted, what steps would you take to implement your infectious disease policy?
A. Now, are you saying known antigen positive?
Q. Yes.
A. I would refer him to an oral surgeon.
Q. Why?
A. Because I would feel that he would be better capable of handling it there.
Q. Why is that?
A. Because they feel comfortable handling those.
Q. Do you – have you ever reattached – reimplanted an avulsed tooth?
A. Yes.

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Q. Assuming that a patient arrived at your office needing a cavity filled and indicated that he was HIV positive, what steps would you take to implement your infectious disease policy under those circumstances?
A. I would tell them that I would be glad to treat him in a hospital environment.
Q. Okay. Where would you treat them?

A. I'm not sure. I would have to find out now.
Q. Assuming that a patient who was HIV positive presented at your office with an avulsed tooth that needed to be reimplanted, what steps would you take to implement your infectious disease policy?
A. I would refer him to one of the oral surgeons.
Q. Why would you do that?
A. Because he could treat them.
Q. How many times have you reimplanted an avulsed tooth?
A. It's not a frequent thing. Maybe once every two years.
Q. Okay. And is that a dental procedure that you consider to be generally within the realm of your training?
A. Yes.

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Q. Okay. And competence?
A. In some situations, yes.
Q. Okay. Describe to me why an oral surgeon is more suitable for reimplanting an avulsed tooth in a situation where you would otherwise ordinarily do that.

MR. GILBERT: Are you talking hypothetically, strictly hypothetically?

MR. KLEIN: I'm talking about the situation I have just presented to him.

MR. GILBERT: Well, if hypothetically he could immediately take the patient into a hospital operatory and we didn't have this other issue as to whether he could immediately go in, are you asking him to include or exclude that in the assumption?

BY MR. KLEIN:
Q. Dr. Bragdon, you indicated that if a patient presented with HIV, who was HIV positive and needed an emergency reimplanting of an avulsed tooth, you would refer that patient to an oral surgeon, is that correct?

A. Yes.
Q. And what I am asking you is what concerns of yours – or why would you refer the patient to an

(Page 244)

oral surgeon?
A. Because they have hospital privileges, and they could take them to the hospital without any difficulty, although you do need to realize that I can take any patient on an emergency basis to a hospital.
Q. What hospital?
A. Any hospital.
Q. With respect to the patient that we are talking about presenting with HIV who has an avulsed tooth that needs reimplanting, what hospital would you take him to?
A. I'm not sure at this time. I would have to check to see what the available facilities were.
Q. Are there any conditions other than HIV which you would only treat in a hospital setting?

MR. GILBERT: Object to the form of that question. I don't think there has been any evidence that he has ever undertaken to treat HIV, period.

BY MR. KLEIN:
Q. Let me ask this question: Are there any circumstances under which you would treat a patient you knew to be HIV positive in your private dental office?

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A. You mean outside of an exam and diagnosis?
Q. Is that treatment?
A. I don't know what you mean.
Q. Do you provide dental treatment – under the infectious disease policy, do you provide dental treatment to patients who are HIV positive in your private dental office?
A. No.

Q. Okay. Are there any circumstances under which you would provide dental treatment to patients who you know to be HIV positive in your private dental office?
A. By dental treatment if you mean invasive procedures, no.
Q. Are there any infectious diseases or conditions other than HIV which under your infectious disease policy – strike that. Let me go back.
Under your infectious disease policy, are you willing to treat an HIV-positive patient in a hospital?
A. Yes.
Q. Okay. Are there any conditions other than HIV which you would treat in a hospital setting?
A. Yes. The infectious diseases that are listed here.

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Q. All of them?
A. Yes.
Q. Does that include strep throat?
A. Yes.
Q. So you would treat a patient who is infectious with strep throat in a hospital setting?
A. Yes, I would.
Q. Is that true also of measles?
A. Yes, although you would have to advise them so that if they had any personnel that had not had measles that there wouldn't be – there would no no contact with them.
Q. If who had any personnel?
A. You would have to advise the hospital that you was coming in with somebody with measles so that they could make arrangements so that there wouldn't be any hospital personnel that would have direct contact with them. This would be – again, we are talking in the case of measles an emergency because normally you would wait until the disease had abated and resolved itself.
MR. KLEIN: Can we take a five-minute

break?
MR. McCARTHY: Sure.
(Recess taken from 10:50 to 11:02.)

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BY MR. KLEIN:
Q. Dr. Bragdon, can you tell me why you're willing to treat HIV-positive patients in a hospital?
A. I believe it's the safest setting and also, as I said before, I think that additional measures can be implemented there which aren't practical in a private office.
Q. Can you describe your standard procedure in your office when a new patient comes for their first visit?
A. They are given a form for their medical and dental history, asked to fill that out; and then depending on the situation, either just before they come in or when they come in, I review that history and then do an interview with them..
Q. What kinds of questions do you ask in the interview?
A. If there is anything that I have noted on the medical or dental history that I would like to have further clarified, I will ask them about that.
Q. Anything else?
A. I will ask them what was their purpose of coming in and then get, depending on what their purpose was, a brief history or do an exam right then or

(Page 248)

get a brief history and then take a look.
Q. Are there any other questions which you routinely ask each patient or most patients?
A. That's pretty much it.
Q. Assuming that you have a new patient, is there anything that you would do for each patient in terms of the general dental exam assuming it is a patient you had not ever treated before?

A. It depends on what they want to have done. For example, if they have a tooth that is abscessed and they want to extract it, then we would take and do an X-ray, examine the tooth and just take a quick look in their mouth because they haven't asked for, and we wouldn't charge them for, the complete exam.
Q. Assuming that a patient presented with tooth pain, what steps would you take?
A. Depends on what kind of pain they are having.
Q. Well, what are the different things you might do under the different kinds of tooth pain that people present with?
A. Different things would be they may need just – sometimes you can look at it and just touch it and be able to identify the tooth that is bothering. Sometimes you need percussion where

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you tap on the teeth. Sometimes we use ice to determine which teeth are involved, do an examination with a mirror and explorer, may take a periapical X-ray or we might take an extraoral X-ray depending on the situation.
Q. Can you tell me what both those procedures involve, a periapical X-ray?
A. It involves using the – either an intraoral X-ray unit or an extraoral X-ray unit and taking a radiograph.
Q. Okay. Anything else?
A. We are talking strictly tooth pain?
Q. Yes.
A. Sometimes you might check for a cracked tooth.
Q. How do you do that?
A. You take and sometimes tap on different cusps in succession, press outward from the center of the tooth on the various cusps. We also have an instrument we call a bite checker which has kind of a cup point on it, which we have them bite down on different cusps and in the center and see if we elicit responses indicative of a cracked

tooth or not.
Q. Okay. Can tooth pain ever be indicative of related dental issues?

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A. What do you mean by related dental issues?
Q. Is tooth pain ever indicative of other – of the existence of other dental conditions that need treatment?
A. I don't understand the question.
Q. Okay. When a patient presents with tooth pain, can that be a symptom of some other underlying dental problem that may need treatment?
A. I still don't really understand the question. Do you mean outside of the tooth structure itself?
Q. Well, if a patient presents with tooth pain, could that, for example, be indicative of a cavity?
A. Yes.
Q. Okay. And if a patient presents with tooth pain, could that be indicative of other problems or dental needs aside from a cavity?
A. Now, you're asking – this hypothetical patient has come, which I have never seen before –
Q. And complains of tooth pain.
A. And complains of tooth pain.
Q. Right.
A. And upon examination I note that tooth has a cavity.
Q. Right.

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A. And now you are asking me can the pain be due to something else besides the cavity?
Q. Yes.
A. Yes.
Q. Okay. What other kinds of dental problems could tooth pain be indicative of other than a cavity?
A. It could be a sinus infection.
Q. What else?

A. It could be a periapical abscess.
Q. I'm sorry?
A. It could be a periapical abscess.
Q. What else?
A. There could be an abscess in either the pulp chamber or one of the root canals.
Q. Okay. Anything else?
A. There could be a lateral cyst. There could be an interradicular cyst between the roots.
Q. Can you spell that?
A. I-N-T-E-R-R-A-D-I-C-U-L-A-R cyst. It could be a periapical lesion. It could be a cyst or a granuloma. I have had one or two patients that had mestatasized cancer.
Q. Anything else?
A. It could be root fracture. It could be referred pain from another tooth that appears on

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the area of that tooth. Occasionally we get a patient that has got an infection that is either mid face or in the nasal cavities that will kind of settle down in this area here and they will –
Q. You have to say which area so the court reporter –
A. Settle in the inframandibular area.
Q. Where is that in layperson's terms?
A. Along the edge of the lower jaw.
MR. McCARTHY: Right here.
A. And they will sometimes think that this is tooth pain. We have to make that distinction.
BY MR. KLEIN:
Q. Anything else?
A. Once in a great while there is a piece of a primary or baby tooth that has been retained. Sometimes when a patient has lost their baby tooth, a piece of it will remain behind, especially sometimes the root. It's not real frequent, but sometimes a piece of root will eventually work it's way out; and they will be getting some pain from that. If it's between the

teeth, it's hard to see. Sometimes there is another cavity in the tooth that is actually causing the pain besides the one that is readily ....

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Q. Prior to 1991, prior to the changes you made on the form in 1991, how many different versions of your Patient's Registration and Health Record did you use during the course of your practice of dentistry beginning in 1978?
A. Two, maybe three. I can't remember exactly.
Q. Do you recall the first time that you changed your patient's registration form subsequent to 1978?
A. No.
Q. Do you have any approximation of when that was?
A. I really can't remember.
Q. But to the best of your understanding, you modified your patient registration form two or three times between 1978 and up to the time you made these changes in 1991?
A. You have worded that a little different. Before 1991, we've had two to three other forms.
Q. Okay. Prior to 1991 did you ask patients any questions about the existence of AIS, HIV, autoimmune Disease or Immune Deficiency Disease?
A. I can't remember for sure if autoimmune was in there, but we didn't have AIDS or HIV positive on it.
Q. Prior to 1991 before you treated each patient,

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did you ask them if they were HIV positive?
A. No.
Q. Did you ask – prior to 1991 before you treated each patient, did you ask them if they had AIDS?
A. No.
Q. Do you have in your office forms in patient

records that are on the pre-1991 Patient Registration and Health Record forms?
A. We have them filled out, yes.
Q. Yes, okay.
MR. KLEIN: And, John, what I would ask since I do think that is responsive to our document request in terms of all patient history forms is that you produce to us all of the different versions with all information redacted, just the form itself essentially.
A. We could do that.
Q. Thank you.
(Bragdon Exhibit 11-B marked.)
BY MR. KLEIN:
Q. Can you identify Exhibit 11-B?
A. This is the front and back side of my Patient Registration and Health Update.
Q. When was this form written?
A. This would have been in 1991.

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Q. Did you have a patient registration and health update prior to 1991?
A. No.
Q. Is it correct, then, that prior to 1991 the only medical questionnaire or form that a patient filled out was the Patient Registration and Health Record, is that right?
A. Yes.
Q. And was the Patient Registration and Health Record filled out at the time of the patient's first visit to your office?
A. Yes, it was.
Q. Okay. Prior to 1991 when patients came in for visits after their first visit, did you review the Patient's Registration and Health Record with the patient on each occasion?
A. We have a sign that asks them to let us know if there has been any change in their health or medications, and also I generally ask them how they have been and how they are doing.

Q. Other than that did you seek any medical information from patients who were not new patients prior to 1991?
A. Those were the methods we used to update.
Q. Would you tell me everything that you can recall

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about Sidney Abbott's contact with your office?
A. What contact?
Q. Has Sidney Abbott had any contact with your dental office?
A. She made an appointment, which I don't know anything that was involved with that, and then she came in, filled out her registration and health record. I looked at her registration and health record, noted that she had checked HIV positive. She was seated. I asked her if she had any medical problems. She said she was HIV positive, and I asked her what I could do for her. She said she had been to another office and they had advised her that she had a cavity after doing an examination, which she pointed to, and she wanted to know how much it would be for me to restore that cavity; and I told her that I had an infectious disease policy and we didn't treat infectious patients in the office, that I would be happy to treat her in the hospital setting and that the fee would be my regular fee plus whatever the hospital charge was; and she said that she would think about it and get back to me and let me know what she decided. And on the way out she asked if there was any fee, and I said, ...

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A. We use single gloves when we do examinations.
Q. Okay. Did Judith Bragdon ask you anything else?
A. No.
Q. Did you have any conversations with anyone else

in your office on September 16th, 1994, about Sidney Abbott prior to meeting Sidney Abbott?
A. No.
Q. Tell me what happened when Sidney Abbott entered your treatment room. What was the first thing you said to her?
A. I can't remember. Probably small talk. Usually I comment on the weather or something like that, but I can't remember.
Q. Prior to Sidney Abbott's entering your treatment room, had you determined in your own mind whether you would provide dental treatment to her or not?
A. I didn't know what she wanted done.
Q. Prior to Sidney Abbott's entering your treatment room – well, by dental treatment, how do you define dental treatment?
A. I don't understand the question.
Q. Okay. Let me step back and rephrase that. Prior to entering – Sidney Abbott entering your treatment room, had you made any determination about whether you would provide a service to her

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such as filling a cavity?
A. Not specific to her, no.
Q. Okay. Prior to meeting Sidney Abbott, did her HIV status – her HIV-positive status – had you made any decision about what you would and wouldn't provide to her on September 16th, 1994, on the basis of her HIV-positive status?
MR. GILBERT: Are you focusing the witness's attention on the approximately one-minute time frame that he talked about earlier between when he reviewed the form and when he showed the patient into the office, in that one minute?
MR. KLEIN: Right.
BY MR. KLEIN:
Q. Prior to meeting Sidney Abbott.
A. No.
Q. Okay. Describe to me everything you can remember

about what Sidney Abbott said to you and what you said to her.
A. I think I already have.
Q. Okay. Is there anything else?
A. Not that I can recollect right now.
Q. Okay. What – did you take – tell me what type of dental examination or procedures you performed

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on Sidney Abbott?
A. She said – I examined the lesion which she was inquiring about, and then I did a general exam.
Q. Okay. And what does that consist of specifically?
A. Basically, it's a general look at the soft tissue and a general look at the other teeth to see if there is any major problems.
Q. Okay. What instrument –
A. With the mirror and explorer.
Q. I'm sorry?
A. A mirror and an explorer.
Q. Tell me exactly what you did with a mirror and explorer?
A. What do you mean?
Q. How did you use them to perform the dental exam?
A. Took the mirror in my left hand and the explorer in my right hand and examined the teeth. I may have used the mirror to retract her cheek, too. I sometimes do during an exam.
Q. And you noticed on the health registration form that Ms. Abbott indicated that she had a toothache?
A. Yes.
Q. And did you take any steps to determine whether

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Ms. Abbott's toothache was indicative of something other than a cavity such as the – such as the dental conditions which you described earlier that can be – that a toothache would be

indicative of?

A. No, because I did ask her if it was bothering her, and she said no. She said that she had been recently examined by another dentist.

MR. KLEIN: Can we have this as the next exhibit?

(Bragdon Exhibit #14 marked.)

BY MR. KLEIN:

Q. Can you identify Exhibit 14?

A. Yes. This is the record of Sidney Abbott with the front and back page.

Q. Can you please read into the record all of the notations that you placed on that record?

A. "9/16/94, buckle decay, number 18. HIV diagnosed eight years ago. Wants to know cost. 35 to 45 dollars. Would have to do in hospital outpatient because of infectious disease policy. Will think about and get back to us." And it's noted under the charges, no charge.

Q. If Sidney Abbott had not indicated on the Patient Registration and Health Record that she is HIV ....

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Q. Describe to me the circumstances under which you would have filled Sidney Abbott's cavity.

A. If she had indicated that she wanted to have it done, I would have made arrangements, if possible, to do it in a hospital setting.

Q. What hospital?

A. I'm not sure.

Q. Why aren't you sure?

A. Because I've never had to take and make arrangements for such a thing.

Q. What hospital would you have attempted to treat Sidney Abbott in?

A. Probably Downeast Memorial Hospital.

Q. Where is that?

A. In Machias. Did I say Downeast Community Hospital?

Q. That's in Machias?

A. Yes.

Q. How many miles is Machias from Bangor?

A. I'm not sure.

Q. Do you have an estimate?

A. Probably 60 miles or thereabouts.

Q. Are there any other hospitals aside from Machias that you would have considered treating Sidney Abbott in?

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A. I would have considered Eastern Maine or St. Joseph's Hospital.

Q. Any others?

A. No.

Q. Where is St. Joseph's Hospital located?

A. In Bangor.

Q. As of September 16th, 1994, you did have privileges at – to use the facilities of any hospital, is that correct?

A. That is correct.

Q. And prior to September 16th, 1994, had you ever inquired about obtaining privileges at any hospital?

A. No.

Q. And had you ever even inquired about the process for obtaining privileges at any hospital prior to September 16th, 1994?

A. No.

Q. Okay. At some time subsequent to September 16th, 1994, did you have any communication with the Eastern Maine Medical Center?

A. No.

Q. Okay. At some time subsequent to September 16th, 1994 – strike that. On September 16th, 1994, if Ms. Abbott had wanted you to fill her cavity, was

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Eastern Maine Medical Center the first place that you would have inquired into with respect to

using a hospital operatory?
A. Yes.
Q. All right. And at some time after September 16th, 1994, did you learn anything about Eastern Maine Medical Center that would affect your ability to obtain privileges there to use a dental operatory?
A. Yes.
Q. What did you learn?
A. I learned that you were planning to depose Dr. Paul LaMarche.
Q. When did you learn that?
A. From my counsel, John McCarthy.
Q. When did you learn that?
A. I can't remember for sure.
Q. Continue.
A. And that flagged us that there must be some problem at Eastern Maine which you planned to amplify on. So with that I called Dr. Chris Maller.
Q. Can you spell the last name?
A. M-A-L-L-E-R.
Q. Okay. Was that prior to LaMarche's deposition?

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A. Yes.
Q. And who is Dr. Maller?
A. He is a general dentist in Bar Harbor who also has an office up here.
Q. In Bangor?
A. Yes. I knew he did some hospital dentistry, and at the time I thought he was in the Eastern Maine facility. So I was going to inquire about their facilities and application and whatnot. He advised me that the head of dental services at Eastern Maine was also the head of dental services at St. Joseph's Hospital. It was a problem in that he was against general dentists working in a hospital setting.
Q. Who is the head of dental services at Eastern Maine Medical Center that you are referring to?

A. Dr. Daniel McCarthy.
Q. What else did Dr. Maller tell you?
A. He told me that as a result he couldn't make any headway with getting hospital privileges at Eastern Maine, and he understood that they had allowed the dental facility to deteriorate.
Q. Did he tell you specifically how they – did he tell you specifically or – did he tell you specifically what kind of dental facility they ....

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A. He is a general dentist –
Q. Okay.
A. -- who is head of dental services down there.
Q. How did you get Dr. Dorr's name?
A. I knew him. I knew he was doing hospital dentistry down there.
Q. All right. How did you know that?
A. Previous conversations.
Q. What was your conversation with Dr. Dorr?
A. I asked him about getting courtesy privileges, and his response was: Do you have an HIV patient that you want to treat? And I said I may have. And he indicated he didn't think there would be any problem with getting privileges and sent the application form out the next day.
Q. Okay. Did you first tell Dr. Dorr that you may have an HIV-positive patient?
A. No. He asked me.
Q. Okay. So you didn't mention – he asked you whether you had an HIV-positive patient that you wanted to treat prior to your mentioning anything about having an HIV-positive patient, is that right?
A. Let's back up a bit. I asked him about the hospital privileges, and that was his response

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because he is aware of my infectious disease policy.

Q. All right. Was Dr. Dorr at the time that you called him aware of the litigation in the case known as John Doe versus Randon Bragdon?

A. Yes, he was.

Q. How was he aware of that; do you know?

A. From the mailings.

Q. What mailings?

A. That I had mailed out to the members of the dental society in '91.

Q. Did those mailings reference the lawsuit brought by John Doe?

A. Yes.

Q. Had you prior to this conversation had any –

A. Let me think here a minute. It referenced the proceedings of the Maine Dental Society. It may not have been the lawsuit itself. I believe there had been an article or two in the paper, or three.

Q. Prior to your conversation with Dr. Dorr about obtaining privileges at Machias, had you ever had a discussion with him about your infectious disease policy?

A. No.

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Q. Okay. Had you ever had a discussion with him about the previous lawsuit against you brought by John Doe?

A. No.

Q. What else did you discuss with Dr. Dorr in this conversation?

A. That was it. That wasn't it. I asked him what they had for a facility there, if we would be able to do general dentistry, and he said yes.

Q. Tell me everything you know about the facilities for dentistry at Machias.

A. He said that they had a chair, delivery unit and a hospital operatory for it.

Q. Is that everything you would need?

A. It was the best I could find at the time.

Q. Well, is it everything you would need?

A. It's not everything I desire. It's the best we could do. That's why we have worked hard to get three state-of-the-art facilities here in the state because we recognize that what we need isn't available.

Q. What is your understanding of the infection control capabilities of the hospital operatory at Machias?

A. I haven't been down there to actually see it, so

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I would have to inspect it, but my understanding is that, one, we would be able to wash it down completely after use. I would be able to set up so that virtually everything that couldn't be autoclaved could be disposable.

Q. Anything else?

A. And they had a filtered-air system?

Q. What do you mean by a filtered-air system?

A. That the air would be filtered for airborne pathogens.

Q. Okay. Is that everything?

A. That's all I'm sure of or I feel sure of.

Q. Have you ever been to Machias to inspect their facilities?

A. No.

Q. Did you ever make any inquiry about the nature of the infection control capabilities of the facilities at Machias other than this conversation you are relating with Dr. Dorr?

A. No.

Q. If you had privileges to use the facilities at Machias on September 16, 1994, would you have treated Sidney Abbott in that facility?

A. Yes.

MR. GILBERT: You're assuming for ....

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report, you indicate that prior to receiving dental treatment in the hospital operatory the patient should have a monitoring of eye conditions, is that correct?

A. Yes.

Q. And what is the purpose of that?

A. To make sure that they are not having problems with HIV disease affecting their eyes.

Q. And how is monitoring of the eye conditions relevant to providing dental treatment to an HIV-positive person?

A. If you are treating a patient who has got a serious illness such as HIV, you do want to be assured that they are getting good medical care; and these are items that somebody who is getting good medical care should be getting.

Q. Are these numbers one through four prerequisites to your providing dental treatment to an HIV-positive patient?

MR. GILBERT: You're talking about paragraph four, subs one through four?

MR. KLEIN: That is correct. Thank you.

A. In consulting their physician, yes.

BY MR. KLEIN:

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Q. No. I am talking about Roman numerals one through four of paragraph four. Are those prerequisites to your providing dental treatment to a patient with HIV?

A. This is considered what an HIV patient should be getting for good medical care.

Q. And my question is are those tests prerequisites to your actually providing dental treatment to an HIV-positive patient?

MR. McCARTHY: Are you intending to separate those out from the paragraph up above which refers to the requirement of consultation

with a physician? These do not seem to be free standing. You can make them free standing, but I want to make sure you make that question clear to Dr. Bragdon if that is what you are doing.

MR. KLEIN: Well, yes. He is asking if those things have been done, I assume, as part of his medical evaluation.

Q. Is that right?

A. That's right.

Q. So my question to you is is number one – Roman numbers one through four of paragraph four prerequisites to your providing dental treatment to an HIV-positive patient?

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A. They are what is recommended for good routine medical care and follow-up on an HIV patient. I would be interested in whether or not they are getting that care.

Q. All right.

A. An individual physician may provide for one of these items in a different way. So, you know, it's not hard and fast, but we are certainly interested in whether or not they are being evaluated on a regular basis in pointed areas for the condition of HIV disease.

Q. All right. Is it your position that you will not treat a person with HIV who in your personal opinion is not receiving good medical care?

A. That's right.

Q. Do you have – have you ever treated any patient who is on cancer chemotherapy?

A. Yes.

Q. Have you ever treated any patient with diabetes?

A. Yes.

Q. Have you ever treated any patient with lupus?

A. I don't think so.

Q. Have you ever treated any patient with any other kind of immunodeficiency or immunosuppressed condition other than cancer chemotherapy and

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diabetes other than HIV?
A. I think we have one patient with bone marrow transplant.
Q. Anything else?
A. Did you say leukemia?
Q. No. Have you treated patients with leukemia?
A. Yes.
Q. Any other immunocompromised patients?
A. We have got diabetes. You have got diabetes?
Q. Yes, I do.
A. Hodgkin's disease. There may be one or two others, but that's what comes to mind now.
Q. With respect to patients for each of the immunocompromised conditions that you have just answered, tell me all medical evaluation that you obtain prior to providing dental treatment.
A. These patients are under the regular care of a physician.
Q. Is it accurate, then, that when patients have the immunocompromised conditions of chemotherapy, diabetes, bone marrow transplants, leukemia and Hodgkin's disease you do not require specific medical consultation and evaluating?
A. No, because I know they are under regular care. I do – if we have a specific question, I will ....

DEPOSITION OF RANDON BRAGDON, D.M.D.
TAKEN ON JUNE 13, 1995 AND JUNE 14, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption omitted in printing]

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BY MS. PERLEY:
Q. Dr. Bragdon, you testified last week that you had reviewed your own expert report, that of Dr. Kuvin, that of John Molinari and that of Dr. Greenspan. Had you reviewed anything else in preparation for the deposition?
A. No.
Q. Had you looked at the deposition transcript from the case known as Doe versus Bragdon?
A. Yes.
Q. Had you ever read the opinion from United States versus Morvan?
A. Yes.
Q. And when was that?
A. About four weeks ago, I think.
Q. Did you review any of the other expert reports from the Morvan case besides that of Dr. Greenspan?
A. I – during one of our breaks, John McCarthy gave

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A. He thought there was a risk in the office and that he didn't have the training and knowledge to treat an HIV positive patient.
Q. Did you agree with his position?
A. Yes.
Q. Do you think you have the training and knowledge to treat a person with HIV?
A. Not completely, but basically, yes.

Q. When you say not completely, what do you mean by that?
A. Well, our knowledge of HIV and treatment is increasing exponentially, and it's a continually changing sort of thing, so it takes quite a bit of effort to keep up.
Q. But for the most part, you think you do have the knowledge to treat a person with HIV?
A. Yes.
Q. Okay. Have you reviewed anything since last week's deposition in preparation for today?
A. As far as case notes and whatnot, no.
Q. Did you look at any particular articles since last Wednesday?
A. I looked at the ADA Journal that came in yesterday, and there's been a couple MMWRs.
MR. McCARTHY: You are swallowing you

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words just a little bit.
A. Okay. I will try to talk more clearly for you.
Q. What MMWRs are you referring to?
A. The one that came last week and the one that came in the mail yesterday.
Q. Did either one contain any pertinent articles about HIV or tuberculosis or anything related to this case?
A. The one last week contained an article about transmission from patient to patient in Columbia, a dialysis patient.
Q. When you say patient to patient, transmission of what?
A. HIV.
Q. And what did the article said?
A. The article said that the transmission appeared to have occurred as a result of a dialysis patient seroconverting after dialysis had been begun for that patient and that the cause was believed to be sharing the same needles for the entry into the patient's body, and then disinfecting them in a quatramonium disinfectant, which isn't approved in

this country.
Q. Is or is not?
A. Is not.

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Q. And why isn't it approved?
A. Because it's been found ineffective against HIV.
Q. Were these needles heat sterilized or only cold sterilized?
A. They were cold sterilized.
Q. Okay. And what was your reaction to the article?
A. I don't know as there was any reaction.
Q. Okay. Did you review any other documents in preparation for today?
A. No.
Q. Nothing else at all?
A. No.
Q. Did you review the transcript from last week's deposition?
A. No.
Q. What about the articles that your counsel provided to us at the end of last week, did you provide those to your counsel after the deposition?
A. Yes, I did.
Q. And what did you do to find those particular articles?
A. Just went back to my office and pulled them out.
Q. And your reason for pulling out those particular articles was what?
A. You had asked for them.

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Q. Okay. Besides Dr. Kuvin, Dr. Day, -- I'm sorry, you said you did not talk to Dr. Kuvin. Besides Dr. Day and Dr. Morvan, have you discussed the facts of this case with any other so-called expert?
MR. GILBERT: Are you talking about potential trial experts or are you talking about people who are so-called retained experts, or are you talking about people just in the field

generally?

MS. PERLEY: All of the above.

A. As far as other retained experts, no. I suppose I have talked about the case to a number of colleagues and whatnot as far as casual conversation goes, and a number of patients too.

BY MS. PERLEY:

Q. When you say a number of colleagues, are you talking within the Bangor area or outside of Bangor?

A. Both.

Q. Have you talked to anyone outside of the State of Maine?

A. Yes.

Q. At your initiation or at theirs?

A. Both.

Q. Where have these conversations occurred?

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A. Yeah, 60. That would be a ratio of somewhere between one in 50, one in 60.

Q. What, in your view, is the risk of transmission in your dental office of HIV from an infected patient to a member of your staff?

A. If they receive a percutaneous injury, it would be the same.

Q. And again, can you quantify the risk of a staff member receiving a percutaneous injury from a particular patient?

A. No, I don't think I can.

Q. What, in your view, is the risk of transmission in your dental office of HIV from an infected patient to another patient in your office?

A. What is the risk?

Q. Of transmission of HIV from an infected patient to another patient in your office.

A. I don't know.

Q. Is it your position that there have been documented instances of transmission of HIV in the dental office from an infected patient to a dental health

care worker?

A. Repeat that question, please.

MS. PERLEY: Could you please repeat it.

(Pending question read back.)

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A. What do you mean by documented?

Q. What do you mean by documented?

A. You are asking the question.

Q. I'm asking – you can answer it however you want, your understanding of what is a documented instance of transmission.

A. The CDC has different classifications for reporting, and technically they don't list any documented transmissions, but I believe now they list seven dental workers for which they can find no other risk factor, and then in the OSHA blood pathogens standard OSHA reported that CDC had reported to them that there was documented transmission.

Q. In a dental office?

A. Yes. That doesn't seem to appear in the documentation, so I'm not sure if they were using two different sets of criteria or what.

Q. To your knowledge, other than the seven instances which you just described are there any other instances of transmission that you know about from an infected patient to a dental health care worker in the dental office?

A. No.

Q. Are there any instances that you know about,

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documented or undocumented, of transmission from a dental health care worker to a patient?

A. Did you say other instances?

Q. Any instances that you know of of transmission of HIV from a dental health care worker to a patient in the dental operatory.

A. The Dr. Acer/Kimberly Bergalis case.

Q. Anything other than that?
A. No.
Q. To your knowledge, are there any instances of transmission, documented or undocumented, from an infected patient to a noninfected patient in the dental operatory?
A. There's I believe it's the Sharp's case that was in Massachusetts which is felt that there may have been a transmission from patient to patient by nonheat sterilized hand pieces or some other mode.
Q. Anything else?
A. That's the only one I know of of patient to patient.
Q. So am I correct then that to your knowledge there have been seven undocumented possible instances of transmission from patient to health care worker, only one possible case of transmission from health care worker to patient and only one possible case

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of transmission from patient to patient in the dental operatory, is that correct?
A. That's correct.
Q. Okay. With the Sharp's case you said you believe it's because of the unsterilized hand piece, is that right?
A. That was what they cited as being what they felt was the primary problem.
Q. Do you know whatever happened to that case?
A. No, I don't.
Q. So you don't know if it's ever been proven the there was actual patient to patient transmission?
A. No.
Q. Given your infectious disease policy I take it that you believe the risk of transmission of HIV in the dental operatory in your office is not acceptable to you, is that right?
A. That's right.
Q. But you're willing to treat the patient – an HIV positive patient in the hospital operatory, is that right?

A. Yes.
Q. So that risk is acceptable to you, right?
A. It's the best I can do.
Q. Last week when we were talking you mentioned a ....

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Q. And if the patient indicates that they do not have TB, do you treatment in the office?
A. Yes.
Q. But you don't do that for people who are HIV positive, is that right?
A. Don't do what?
Q. Let me withdraw the last question. Do you do any screening at all to determine whether some patient may have a higher than average risk of being – of having tuberculosis?
A. We don't do any group screening at all.
Q. Have you contacted any dentist about being an expert witness for you in this case?
A. No.
Q. Have you contacted any dentist and asked for their opinion about your infectious disease policy?
A. No.
Q. Dr. Bragdon, in the documents that you have produced to us in this case there were copies of the magazine Pause. Are you familiar with that magazine?
A. Yes.
Q. And can you tell us how you came into possession of the magazine Pause?
A. There were issues of it given out at the meeting in

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Chicago.
Q. And that's the meeting in October of 1994?
A. Yes, it was.
Q. Can you tell me all of the journals that you subscribe to currently?

A. I may not remember them all.
Q. At the current time.
A. I get the Journal of the American Dental Association – do you want publications, too, or just journals?
Q. Everything that you get in the mail that's a journal or a publication.
A. Okay. The ADA News, the Journal of the Academy of Dentistry, AGD Impact Magazine. I get the newsletter of the International Dental health Foundation, the publication of the American Orthodontic Society, the publication of the International Association of Orthodontics, the Journal of the International Physicians for AIDS Care. They have changed the name. I can't remember exactly. I think that's pretty close. Dental Economics, Dentistry Today. These are – aren't really journals, they are just kind of publications. That's pretty much it.
Q. What are the journals or publications that you

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subscribe to or receive currently other than the dental journals that you have just referred to?
A. Pardon?
Q. What are the journals or publications that you currently subscribe to or receive other than dental journals you have just named?

MR. GILBERT: Are you asking him what he puts out in his waiting room, Reader's Digest or that type of thing?

MR. KLEIN: I'm asking everything that he receives in the office or at home.

MR. GILBERT: Well, that would include what he puts out in the waiting room, Reader's Digest. Is that what you want?

A. Reader's Digest, Good Housekeeping, Popular Mechanics, Country Home, Reminiscing.
Q. Pardon?
A. Reminiscing.
Q. Are those journals that you subscribe to for

purposes of putting out in your waiting room?
A. Yeah.
Q. What other journals do you personally subscribe to and receive at home or the office other than things that you are intending to put out on your waiting room table?

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A. That's pretty much it.
Q. You don't receive any journals or publications that are not related to dentistry?

MR. McCARTHY: You mean other than Good Housekeeping?

MR. KLEIN: Pardon?

MR. McCARTHY: I guess I'm misunderstanding.

Q. Are there any journals other than Reader's Digest, Good Housekeeping, Popular Mechanics, Country Home and Reminiscing that you subscribe to that are not dental journals that you have not already named?
A. That's all I can remember right now.
Q. Do you receive any publications from the Maine Dental Association?
A. Oh, yes, MDA Journal.
Q. Are there any other publications of the Maine Dental Association you receive?
A. That's a newsletter that comes out once a month.
Q. Are there any other Maine Dental Association publications or journals which you receive?
A. That's the only thing they put out on a regular basis. Then there's a monthly newsletter from the Penobscot Valley Dental Society.
Q. Are there any other publications of the Penobscot ....

DEPOSITION EXHIBIT 13 TO BRAGDON DEPOSITION OF JUNE 13-14, 1995

[Filed September 19, 1995
D.C. Me.]

PATIENT REGISTRATION AND HEALTH RECORD

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

[PATIENT RESPONSES ITALICIZED]

Date: *09/16/94*

Marital status: *Divorced*

Name: *Sidney Abbott*

Phone: *989-7017*

Address: *16 State St., Apt. E, Brewer, Maine, 04412*

Referred by: *a friend*

Employed by: *Penobscot Area Housing*

Position: *Dir. Serv. Worker*

Business address: *215 French St., Bangor, Maine*

Phone: *942-3994*

In case of emergency, who should be notified: *Melinda Perrier*

Phone: *947-2367*

Person responsible for this account: *Me*

Social Security No.: *006-68-6050*

Medical Health

General health: *Good*

Are you presently under the care of a physician: *Yes*

What medications are you presently taking: (blank)

Physician: *Rob Pinskey*

Last complete physical: *Jan.*

What disorders are you presently being treated or have been treated for within the past year: *HIV*

Please list any serious illness within the past five years, not listed above: (blank)

Have you been told by a physician that you should have prophylactic antibiotics before having dental procedures done: *No*

General Health

Tire easily: *No*

Headaches: *Yes*

Night sweats: *No*

Persistent fever: *No*

Glaucoma: *No*

Persistent cough: *No*

Sputum (phlegm) production: *No*

Cough up bloody sputum: *No*

Marked weight change: *No*

Shortness of breath: *No*

Have you been diagnosed or treated for:

Heart disease; Asthma or hay fever; Rheumatic or Scarlet fever; Abnormal blood pressure; Congenital heart lesions; Tuberculosis or lung disease; Diabetes; Epilepsy; Anemia; Ulcers; Jaundice; Hepatitis; Sinus trouble; Cough; Arthritis; Stroke; Glaucoma; Immune deficiency disease; Autoimmune disease; AIDS: *No* [to all the above.]

Heart murmur; HIV positive: *Yes*

Have you ever had radiation therapy: *No*

Chemotherapy: *No*

Are you allergic to penicillin; Codeine; Local injected anesthetics; other allergies: [blank]

Other medications: *Bactrim.*

Are you subject to prolonged or unusual bleeding, fainting spells or dizziness: *No*

Are you pregnant: *No*

Dental Health

Reason for visit: *Tooth ache*

Have you ever had any serious trouble associated with previous dental treatment: *No*

Does dental treatment make you nervous: *Slightly*

Does dental treatment make you nervous: *Slightly*

Date of last dental visit: *August, 1994*

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth): *No*

Do you have or have you ever had any of the following:

Mouth

Bleeding, sore gums; biting cheeks/lips; sensitive to sweets: *Yes*

Unpleasant taste/bad breath; burning tongue/lips; frequent blisters, lips/mouth; swelling/lumps in mouth; ortho treatments (braces); clicking; popping jaw; difficulty opening or closing jaw; loose teeth; sensitive to hot, cold; sensitive to biting; food impaction; clenching/grinding; shifting of teeth; change in bite: *No*

Do you use the following:

Brush, dental floss: *Yes*

Fluoride rinse: *No*

How often do you brush: *Twice a day*

Brush is soft, medium, hard: *Medium*

Toothpaste: *Tom's.*

Are you familiar with the term "preventive dentistry:" *Yes*

/s/ Sidney Abbott

Date: 09/16/94

DEPOSITION OF DONALD CRAVEN, M.D., TAKEN IN BOSTON, MASSACHUSETTS ON JULY 21, 1995

(Caption omitted in printing)

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Q. Am I correct that there are patients who are HIV positive and have no symptoms?

A. Yes.

***

Q. Are some of your patients pregnant?

A. Yes.

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Q. And do you treat any patients who are pregnant? I guess I'm using "you" broadly. Do you treat these patients yourself?

A. Some.

Q. Do you treat some of these patients who are HIV positive and are pregnant with AZT?

A. Yes.

Q. Does that have a positive effect?

A. Yes.

Q. Does that in some cases permit them to bear children successfully?

A. It doesn't have to do with bearing children. It has to do with decreasing the transmission of the virus to their child.

Q. Thank you. So in some of these cases where you're treating

pregnant women, you among other things treat them with AZT, and that reduces the likelihood that the child will be born after having had the HIV virus transmitted to it?

A. Yes.

Q. To what extent is that successful?

A. The latest studies that have been published suggest that women treated throughout pregnancy, at birth and after pregnancy and

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children that are born and treated for a period of time after birth decreases transmission 67 percent. 25 percent in an untreated AZT group or 8 percent for AZT treated women. There's a two-thirds reduction of infectivity of the children.

Q. So the infectivity rate to begin with is 25%?

A. Right.

Q. And with the treatment of AZT it can be reduced to 8 percent?

A. In one study.

Q. Is that a reliable study?

A. Yes.

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Q. Do you sometimes recommend to HIV positive patients that they not get pregnant?

A. I don't make recommendations about pregnancy to patients. I discuss what the risks are and what the concerns are and leave the decision about pregnancy to the patient, unless there's an overall compelling reason why the woman's health would be

greatly impaired if she became pregnant having to do with issues aside from HIV.

Q. And in order to make that judgment, you would need to obtain a history from the patient, and you'd need to look at her medical records; is that right?

A. In general I don't make recommendation to women. Let me make it more categorical than that. I have not made a recommendation to a woman yet. But I could see if there were some circumstances, that I would make a recommendation to any woman if I felt that pregnancy would impair her health that she should consider not becoming pregnant.

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But I leave the decision about pregnancy to the woman. I try to provide information about what the risks are and what the different values are, but the decision to become pregnant is not one that I take a stand on with a patient. I basically try to inform them and let them make the decision based on the information about risk that I give them.

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AFFIDAVIT OF DONALD E. CRAVEN, M.D. DATED 09/13/95

[Caption omitted in printing]

I, Donald M. Craven, M.D., state as follows:

1. I am a professor of Medicine and Microbiology at Boston University School of Medicine and Professor of Epidemiology and Biostatistics at Boston University School of Public Health. I have been the Director of the Clinical AIDS Program at Boston City Hospital since 1990. I have been the primary care physician for more than 75 patients with human immunodeficiency virus (HIV) or acquired immunodeficiency virus (AIDS) and have been a consultant for hundreds of patients with HIV or AIDS. I incorporate into this Affidavit my Curriculum Vitae (Exhibit A) and the opinions set forth in my Expert Report in this case (Exhibit B).

2. HIV is a retrovirus which is the causative agent of AIDS. A person who has been infected with HIV will, after a period of one to six months, develop antibodies, thus becoming HIV-positive. The collection of illnesses which characterizes AIDS may not appear for seven to twelve years after seroconversion. During much of this period, an HIV-positive person may be asymptomatic.

3. However, even when asymptomatic, an HIV-positive person is infectious and has abnormalities in the blood and immune systems. When HIV enters the body, it begins to multiply and has an immediate and destructive effect on the hematologic (blood) and lymphatic systems. HIV destroys the T-4 lymphocyte and other white blood cells, which are critical to the body's defense against infection. In addition, HIV destroys the body's lymph glands which are the command center for the immune system's attempt to contain infection. Thus, even before the onset of overt symptoms, HIV infection causes a progressive destruction of the body's blood, lymphatic and immune systems.

4. The modes of transmission of HIV are well

known. HIV is transmitted by sexual contact with an infected person; exposure to blood or blood products; or from an infected mother to her child during pregnancy, child birth or breast feeding.

6.[sic]. In order to estimate the number of dental procedures performed in the United States since 1982, I am making the following assumptions. I assume that there are 150,000 practicing dentists. See Distribution of Dentists in the United States by Region and State, American Dental Association, 1991, Exhibit C. In addition, I am told that Dr. Bragdon testified that he sees about sixty patients per week. I will make a conservative estimate that Dr. Bragdon actually performs dental procedures on thirty patients per week. I am therefore assuming that most general dentists perform dental procedures on about 30 patients per week. I assume that the average dentist works 48 weeks per year.

8.[sic]. Based on those assumptions, I calculate that there have been 2.8 billion dental procedures performed in the United States from 1982 to present. If I assume that the average dentist performs only 15 procedures per week, the number of dental procedures since 1982 would be 1.4 billion. These estimates do not include the 100,000 dental hygienists in the United States (See Exhibit D). If dental hygienists were included, the number of dental procedures performed since 1982 would be significantly higher.

9. Since 1982, the United States Centers for Disease Control and Prevention (CDC) has monitored occupational transmission of HIV in the health care setting. During that time, there has not been a single documented case of HIV transmission from a patient to any dental health care worker, including dentists, hygienists and chairside assistants. Based on the current epidemiological data, the probability of HIV transmission in the future from patient to dental health care worker is infinitesimally small or negligible, and significantly less than the risk of death in many other events both within and outside the health care setting which are commonly treated as reasonably safe activities.

10. Since 1982, there have not been any documented cases of patient-to-patient transmission of HIV in the dental setting.

11. There is a wide spectrum of risk associated with a variety of health care procedures. For example, risk of dying from acute anaphylaxis from penicillin is between 1 in 50,000 and 1 in 100,000, resulting in approximately 400 to 800 deaths per year. See Erffmeyer, Adverse Reactions to Penicillin, Annals of Allergy, Vol. 47, October 1981, p. 288, Exhibit E; Landesman, The HIV-Positive Health Professional, Archives of Internal Medicine, Vol. 151, April 1991, p. 655, Exhibit F. The risk of death from anesthesia is 1 in 400,000. See Voelker, Anesthesia-Related Risks Have Plummeted, Journal of the American Medical Association, February, 1995, Vol. 273, No. 6, Exhibit G.

12. According to the most recent National Safety Council statistics, which are for the year 1986, there are also risks associated with everyday activity. The risk of death from a motor vehicle accident in Bangor, Maine is 9.5 per 100,000 population per year. In 1986, 119 people died from falling into a hole or other opening in a surface. In that same year, 78 people died as a result of being struck by lightning. See excerpts from Accident Facts, published by the National Safety Council, Exhibit H.

SIGNED UNDER THE PENALTIES OF PERJURY THIS 13th day of September 1995.

/s/ Donald E. Craven, M.D.

[EXHIBIT A]

CURRICULUM VITAE

Donald Edward Craven

PERSONAL INFORMATION:

Birth: January 13, 1944, Omaha, Nebraska

Address: Home:
20 Clifford Street
Wellesley, MA 02181
617-237-7851

Office:
Boston City Hospital
818 Harrison Avenue
Boston, MA 02118
(617) 534-4800 FAX 534-7818

Family: Kathleen Walsh Steger
Natalie Adrienne (9/84)
Hillary Elyse (4/88)
David Allen (4/82)
Jenny Lee (4/84)

SS# 094-34-4205

EDUCATION & PROFESSIONAL TRAINING:

1966 BA, Wesleyan University, Middletown, Conn.
1970 MD, Albany Medical College, Union University, Albany, NY
1970-71 Intern, Albany Medical Center Hospital, Albany, NY
1971-74 Resident and Fellow in Medicine, Royal Victoria Hospital, McGill University, Montreal, Canada
1974-76 Fellow in Infectious Diseases, Boston University, Boston, MA
1976-79 Research Associate, Bureau of Biologics, National Institutes of Health, Bethesda, Md.

ACADEMIC APPOINTMENTS:

1989- Professor of Medicine and Microbiology, Boston University School of Medicine (BUSM), Boston, MA
1989- Professor of Epidemiology and Biostatistics, Boston University School of Public Health (BUSPH)
1984-88 Associate Professor of Epidemiology and Biostatistics, BUSPH
1986-88 Associate Professor of Microbiology, BUSM

1983-88 Associate Professor of Medicine, BUSM
1982-83 Assistant Professor of Epidemiology and Biostatistics, BUSPH
1979-83 Assistant Professor of Medicine, BUSM

MEDICAL APPOINTMENTS:

1989- Director of Clinical AIDS Section, Boston City Hospital
1988- Associate Visiting Physician, Boston City Hospital
1990-93 Associate Director of Medicine, Boston City Hospital
1987-88 Associate Director of the AIDS Clinic, Boston City Hospital
1987-88 AIDS Public Health Director, Department of Health & Hospitals
1980-87 Director of Hospital Epidemiology, Boston City Hospital
1979-88 Assistant Visiting Physician, Boston City Hospital
1979-87 Hospital Epidemiologist, Boston City Hospital
1984-88 Lecturer, Harvard Medical School
1984-90 Staff Associate, University Hospital
1986-88 Lecturer Boston University Dental School
1986-89 Lecturer, Harvard School of Public Health
1974-76 Emergency Room Physician, Memorial Hospital, Nashua, NH
1973-74 Associate Director, ID Clinic, Royal Victoria Hospital
1976-79 Mountain Medicine, Editor & Writer, Potomac Appalachian Club
1971-73 Emergency Room Physician, Memorial Hospital, Watertown, NY
1971-73 Clinic Director, John Abbott College, Montreral, Canada

AWARDS:

1995 Who's Who: Most Outstanding Americans
1991-94 Best Doctors in America
1988-94 Teaching Award, BU School of Public Health
1989-94 Who's Who on the Frontiers of Science
1986 Governor's Recognition Award for AIDS Research
1970 Alice E. Fruehan Award for Outpatient Medicine

1970 Lamb Foundation Prize for Medicine
1969 Cancer Society Fellow, Christie Hospital, Manchester, England

CERTIFICATION:
1971 National Board of Medical Examiners
1973 American Board of Internal Medicine, Internal Medicine
1973 Medical Council of Canada (LMCC)
1975 Royal College of Physicians, Internal Medicine
1982 American Board of Internal Medicine, Infectious Diseases

MILITARY SERVICE:
1970-73 Captain, United States Air Force Reserve
1976-79 Senior Surgeon, US Public Health Service, National Institutes of Health, Bethesda, Md.

MEMBERSHIPS & FELLOWSHIPS:
1981-95 Fellow American College of Physicians
1983-95 Fellow Infectious Diseases Society of America
1976-93 Fellow Royal College of Physicians and Surgeons of Canada
1974-95 American Society of Microbiology
1979-95 Society of Health Care Epidemiology of America
1979-95 Massachusetts Public Health Association
1988-95 American Public Health Association
1979-95 American Association for the Advancement of Science
1980-95 American Federation of Clinical Research
1987-95 American Thoracic Society
1989-93 Critical Care Society

NATIONAL, STATE AND CITY COMMITTEES:
1991-95 Hospital Infection Control Practices Advisory Committee
(HICPAC) Centers for Disease Control, Atlanta, GA
1992-94 HICPAC-Chairperson for CDC Guideline for Prevention
of Nosocomial Pneumonia
1993-94 President, Society of Hospital Care Epidemiology of America (SHEA)

1991-93 Vice-President (President-elect), SHEA
1994-95 American Thoracic Society, Bacterial Infections Assembly
1992 International Program Committee-VIII International Conference on AIDS/STD World Congress, Amsterdam,
the Netherlands
1992 Ad-Hoc Study Section on AIDS, National Heart and Lung
Institute, National Institutes of Health, Bethesda, Md.
1992 Chairman, Search Committee for Editor, Hospital Epidemiology and Infection Control
1989-91 Advisory Board for International Infection Control Conference, Freiburg, Germany
1986-91 AIDS Action Committee Advisory Board
1988 Site Visit Team for National Institute for Childhood Diseases Program Project on AIDS, San Francisco General Hospital
1986 National Institute of Childhood Diseases, Study Section on AIDS
1986-88 Study Group on AIDS and Public Policy, Harvard University
1986-89 Mayor's Committee on AIDS
1990-91 Governor's Task Force on AIDS
1987-91 Massachusetts Hospital Association—AIDS Advisory
Committee
1988-89 Women and Intravenous Drug User Task Force: AIDS Consortium
1984 Reviewer for Heritage Fund, Calgary, Alberta, Canada
1985 National Institutes of Allergy and Infectious Diseases, National Institutes of Health, Special Study Section

HOSPITAL COMMITTEES:
1994 Microbiology Chairperson, Search Committee
1989-92 Clinical Research Center Advisory Board, BUSM & BCH
1988-92 AIDS Task Force, Boston City Hospital
1987-93 Pharmacy and Therapeutics Committee
1979-92 Infection Control, Boston City Hospital
1980-88 Critical Care Units, Boston City Hospital

1980-87 PSRO Committee, Boston City Hospital
1981-87 Institutional Review Board for Human Studies, Boston
City Hospital
1987 Internship Selection Committee, Boston City Hospital

EDITORIAL CONSULTANT:
New England Journal of Medicine
Journal of Infectious Diseases
Reviews in Infectious Diseases
Archives of Internal Medicine
Journal of American Medical Association
American Journal of Medicine
Hospital Epidemiology and Infection Control (Editorial Board)
Chest
American Review of Respiratory Disease
Journal of the American Medical Association (JAMA)
European Journal of Infectious Diseases and Microbiology
Critical Care Medicine
Acquired Immunodeficiency Syndrome

CONSULTANT:
1995 Anneburg Group, Continuing Education for Primary Care Providers
1992-95 Data Safety Monitoring Board, Use of Monoclonal Antibody Against Tumor Necrosis Factor (TNF) for the treatment of Septic Shock, Myles Laboratories
1994-95 Consultant, SmithKlein-Beecham
1994 Consultant, Infectious Diseases in Primary Care, Abbott
1982-87 Hepatitis, Merck, Sharp and Dohme
1982-85 Consultant, Mattapan & Long Island Hospitals, Boston, MA
1984 Reviewer for Heritage Fund, Calgary, Alberta, Canada
1985-88 Health Conference on Aging, New York, New York
1985 National Institute of Allergy and Infectious Diseases National Institutes of Health, Special Study Section
1985-88 Medical Advisory Board, Laboratory of Cellular Immunology and Cancer Diagnosis, Boston University School of Medicine

GRANTS:
Over 100 grants from NIH, NIDA, CDC, Massachusetts Department of Public Health, City of Boston, and Pharmaceutical Companies.

[Scientific Papers and Research omitted from appendix]

[EXHIBIT B]
EXPERT REPORT OF DONALD E. CRAVEN, M.D.
(Undated)

[Caption omitted in printing]

Pursuant to Federal Rule of Civil Procedure 26 (a) (2) (c), this report sets forth the opinions I will advance to rebut the reports of Sanford Kuvin, M.D. and Randon Bragdon, D.M.D. I have reviewed the expert reports of Dr. Bragdon and Dr. Kuvin and the first volume of Dr. Bragdon's deposition conducted on June 5 and June 6, 1995.

I am a Professor of Medicine and Microbiology at Boston University School of Medicine and Professor of Epidemiology and Biostatistics at Boston University School of Public Health.

I have been the primary care provider for more than 75 patients with human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) over the past eight years and have been an AIDS/Infectious Disease Consultant for hundreds of inpatients and outpatients with HIV disease or AIDS. I am familiar with the diagnosis, treatment and mode of transmission of HIV and the various secondary manifestations of AIDS.

I have been the Director of the Adult Clinical AIDS Program at Boston City Hospital since 1990. I have also been the AIDS Public Health Director, the Director of Hospital Epidemiology, and a member of the Infection Control Committee at Boston City Hospital. In these positions, I have been responsible for the implementation, monitoring and surveillance of the hospital's procedures for the control and prevention of infectious diseases, including those in the hospital's dental clinic.

During 1993-1994 I was the President, and during 1991-1993 I was the Vice-President and President-elect, of the Society of Hospital Care Epidemiology of America (SHEA). From 1991-1995, I served on the Hospital Infection Control Practices Advisory Committee (HICPAC) of the United States

Centers for Disease Control (CDC). I have also been elected as a Fellow of the Infectious Diseases Society of America, the American College of Physicians and the Royal College of Physicians and Surgeons of Canada. My additional credentials to provide this expert opinion are contained in my Curriculum Vitae.

Based upon my education, experience and expertise, I expect to advance the following opinions in this case:

1. HIV is a retrovirus which is the causative agent of AIDS. HIV is transmitted by sexual intercourse, exposure to infected blood or blood products, or vertically from an infected mother to an infant.

2. Medical history does not necessarily reveal a patient's HIV status. The majority of patients with HIV are asymptomatic and do not develop medical complications which result in a diagnosis of AIDS for more than ten years. Based on my understanding of the epidemiology and pathogenesis of HIV disease, many people with HIV may not be aware that they are infected.

3. The United States Occupational Safety and Health Administration ("OSHA") and public health authorities such as the CDC have established standard infection control procedures to prevent the transmission of HIV and other bloodborne pathogens from patients to health care workers, from health care workers to patients, and from a patient- to-patient in the health care setting. The fundamental principle of these standard infection control procedures is that all patients must be treated as potentially infectious for all bloodborne pathogens, including HIV, or hepatitis B virus (HBV).

4. The standard infection control precautions ("Universal precautions") established by CDC and OSHA include: barrier techniques such as wearing protective gloves, masks, and gowns; handwashing and changing gloves after each patient; sterilization of instruments; cleaning and disinfection of environmental surfaces in the patient treatment area; and proper disposal of contaminated needles or sharp instruments.

5. No infection control procedures above and beyond the use of the standard infection control procedures established by CDC and OSHA are necessary for the provision of general dentistry services to persons with HIV infection or AIDS. So long as standard infection control procedures are utilized, it is just as safe to treat a dental patient in a private dental office as in a hospital setting.

6. Although HBV and HIV are both blood borne pathogens, they are significantly different with respect to their infectiousness. The viral titre of HBV – i.e., the number of virions per unit of blood – is significantly greater than HIV. In addition, HBV is a much stronger, heartier virus which can survive an inanimate surfaces[sic] for longer periods of time and under more adverse conditions than HIV.

7. To the extent that Dr. Bragdon will only treat HIV-positive patients in a hospital setting because of concerns that HIV-positive patients will transit[sic] Mycobacterium tuberculosis (MTB) to others in the private dental setting, that concern is not justified by current principles of epidemiology and infection control for tuberculosis (TB).

8. MTB is a bacteria which causes TB. MTB is transmitted by inhalation into the lungs of infectious respiratory droplets or sputum from the trachea or lung of a person with active TB. Most people infected with TB do not have active disease. Rather, the disease is latent and noninfectious.

9. The vast majority of people who have active TB are not infected with HIV. A patient's HIV status does not indicate whether or not the patient has latent or active TB. In addition, while HIV-infected persons are at increased risk to proceed from latent infection to active TB, many other persons who are not HIV-infected are also at greater than average risk to proceed from intent to active TB. These higher risk groups include the elderly and and [sic] immunocompromised patients, such as patients with leukemia, diabetes, Hodgkins disease, or persons receiving cancer chemotherapy or other immunosuppressive medications.

10. Active TB is diagnosable and treatable. Any patient with symptoms of TB, regardless of his or her known HIV status, should be sent for TB evaluation prior to receiving dental treatment. If the patient is diagnosed as having active pulmonary TB, the patient should not receive elective dental treatment. The patient should be provided with standard antituberculosis drug treatment. As a result of receiving appropriate treatment, the patient will be noninfectious in approximately two weeks. At that time, the patient may receive dental treatment.

11. Cytomegalovirus (CMV) is a virus which is primarily transmitted through sexual intercourse or exposure to infected blood. CMV is not casually transmitted.

12. Staphylococcus aureus and streptococci are bacteria which are prevalent in all populations, regardless of HIV status.

13. Herpes simplex virus (HSV) types 1 and 2 cause cold sores in the mouth or on the lips. HSV is common in the entire population. HSV infection may be latent (that is, may exist without the manifestation of a sore). HSV is transmitted through contact with infected saliva or kissing. The standard infection control procedures prevent transmission of HSV to health care workers.

14. The various opportunistic infections which people with AIDS may experience do not present a threat to the health of other patients in private health care settings.

15. There is no evidence that HIV is spread through aerosolization.

16. I am not aware of any evidence that HIV survives in water.

17. Dr. Bragdon's infectious disease policy has no scientific or epidemiological basis. Because there is no sound method of determining which patients have infectious diseases, standard infection control procedures, such as those established

by CDC and OSHA, must be used or practiced universally for all patients.

In addition to the publications and documents listed in my Curriculum Vitae, the documents which I reviewed to formulate my opinions include but are not limited to those listed in the attachment to this report.

S/Donald E. Craven, M.D.

DOCUMENTS REVIEWED BY
DONALD E. CRAVEN, M.D.

1. Centers for Disease Control and Prevention: Recommended Infection Control Practices for Dentistry. Morbidity and Mortality Weekly Report (MMWR) 1986; 35:237-241.

2. Centers for Disease Control and Prevention. Recommendations for Prevention of HIV in Health-Care Settings. MMWR 1987; 36 (No. 25).

3. Centers for Disease Control and Prevention: Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B, and Other Bloodborne Pathogens in Health-Care Settings, MMWR 1988: 37:377-382.

4. Centers for Disease Control and Prevention: Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers. MMWR 1989:38 (Suppl. No. S-6): 1-37.

5. Centers for Disease Control and Prevention: Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus during Exposure-Prone Invasive Procedures. MMWR 1991: 40(No. RR-8).

6. Centers for Disease Control and Prevention Recommended Infection Control Practices for Dentistry (1993).

7. Snyder DE, Raviglione M, Kochi A. "Global Burden of Tuberculosis", In: Tuberculosis: Pathogenesis Protection and Control, Barry R. Bloom, editor, ASM Press, Washington D.C. 1994, pp 3-12.

8. Hopewell PC. "Overview of Clinical Tuberculosis" In: Tuberculosis: Pathogenesis Protection and Control, Barry R. Bloom, editor, ASM Press, Washington D.C. 1994, pp. 25-46.

9. Smith PG and Moss AR. "Epidemiology of Tuberculosis" In: Tuberculosis: Pathogenesis Protection and Control, Barry P. Bloom, editor, ASM Press, Washington D.C. 1994, pp 47-61.

10. CDC: "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", 1994, MMWR, October 28, 1994, Vol. 43, #RR13, pp 1-132.

11. CDC: "Guidelines for Preventing Transmission of Tuberculosis in Health Care Settings with Special Focus on HIV-Related Issues", MMWR, 1990, vol. 39, #RR-17, pp. 1-40.

12. American Thoracic Society/CDC: "Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children", 1994 Am J Respir Crit Care Med 1994; 149; 1359-1374

13. Robinson WS. Hepatitis B Virus. In: Principles and Practice of Infectious Diseases, editors: Mandell GL, Bennett JE and Dolin R, Churchill Livingston, New York, 1995, pp. 1406-1439.

14. United States Occupational Safety and Health Administration: Occupational Exposure to Bloodborne Pathogens, 29 CFR Part 1910, 1991.

15. Hirsch MS. Herpes Simplex Virus. In: Principles and Practice of Infectious Diseases, editors: GL Mandell, JE Bennett, R Dolin, Churchill Livingston, New York, Fourth Edition, 1995, pp. 1136-1344.

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DEPOSITION OF DAVID KENNEDY, M.D. DATED 09/01/95

[Caption omitted in printing]

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(Page 5)

Q. All right. And what is the – is that done on an hourly - is there a minimum time-based unit or charge such as 15 minutes or an hour or so forth?

A. There are two types of charges. One is what we call a full operating room charge, and that's generally for inpatients; and then for outpatients we use something called OR/Minor, which there is no minimal charge. The unit of measure is one minute. It's so many dollars per minute. So it could be very little.

Q. Okay. And what would that come to – what would the OR charge be for one hour of time?

A. For OR/Minor?

Q. Yes.

A. I believe it's $5 a minute today. So 60 times 5 is, what, $300? Is that right?

Q. Now, what is the hourly charge for a full operating room?

A. That I don't know off the top of my head.

Q. Is it fair to say it is a greater charge than for OR/Minor?

A. Much greater.

Q. Okay. Would you say – is it your understanding that it would be at least double?

A. Probably triple.

(Page 6)

Q. Does the hourly rate for OR/Minor include – strike that. Let me rephrase the question. Are the OR/Minor rooms ever used by physicians who have privileges at the hospital but are not on the permanent regular staff of the hospital?

A. Rarely but they are used, yes.

Q. Okay. And are the OR/Minor rooms ever used when a physician or other health care provider brings his own equipment and supplies to the hospital?

A. As far as equipment and supplies, I really wouldn't know.

Q. Okay. So you're not aware of whether a physician or other health care provider has ever brought their own supplies and equipment for use in one of the other OR/Minor rooms, is that right?

A. I am not aware of that, no.

Q. Would the charge to a physician include all of the time that the physician or health care provider is actually using the OR/Minor space including any time that they would need to use the space to set up their own equipment?

A. I don't quite understand the question. You said a charge to a physician. I don't think we charge a physician for using the facility.

Q. Okay. I misspoke. Let me clarify that. The

(page 7)

patient is the person who is charged for the use of OR/Minor, is that right?

A. Correct.

Q. And is the patient charged for the entire time that the room is being occupied or used by the physician or health care

provider in connection with the services for the patient?

A. For OR/Minor, I believe that today we are charging from what they call a cut to close, meaning from the time that the patient is actually operated on until the physician is finished and may even leave the room. For inpatient care the charge, I believe, is for threshold to threshold, the time the patient crosses into the room until the time the patient leaves the room.

Q. If a physician needed to use OR/Minor for a period of time to set up equipment and supplies, let's assume just for purposes of this example half an hour of time or an hour of time, would that be included in the patient charge?

A. For OR/Minor I don't believe it would, and usually with OR/Minor there is very little of that setup, and the physician generally doesn't do that. It's my understanding that the nursing

(Page 8)

staff usually has that ready before the patient gets there.

Q. Okay. So is it correct to say that for billing purposes the hospital has never encountered a situation in which an outside provider needed significant time to set up their own equipment and supplies?

A. No to my knowledge.

Q. Okay. And would somebody at the hospital have to make a determination about how that time would be billed?

A. Yes. There is a certain amount of discretion that is used by the head nurse in the operating room, and that's really the person who does the charging. The billing department doesn't actually do the charging. I oversee a lot of the functions and the framework for charging, but the actual charging is done by the OR head nurse.

Q. I just need one moment to see if I have any further

questions. (Brief pause) Directing your attention to Exhibit 1, the second page says OR/Minor, and the patient balance is $1,015. Do you see that?

A. Yes.

Q. And then below it indicates that the time was ...

A Short Critique of the
Recommended M.D.A. AIDS Access Policy
Randon Bragdon, D.M.D.

I hope that you find this critique of the Recommended M.D.A. AIDS Access Policy useful in coming to you own more fully informed conclusions.

> "1. It is unethical for us to refuse to treat a patientt (sic) who is HIV-positive, based solely upon this diagnosis."

Who is "us" anyway. It certainly does not include many dentists and dental schools. It is <u>not</u> unethical to refuse to treat based upon the fact that the patient is infectious with a transmittable disease. On page nine of the April 8, 1991 issue of the A.D.A. News an article titled "Barrier Techniques on Trial in HBV Case" describes how the State University of New York at Buffalo Dental School has a policy of not knowingly treating infectious HBV patients or allowing infectious HBV students in the clinic. I encourage you to read this article (copy enclosed). It makes it clear that to knowingly expose a dental school clinic or private dental office to infectious diseases places that school or office legally liable for any transmitted infectious diseases regardless of what precautions are observed. It <u>is not unethical</u> to treat all infectious diseases the same. What <u>is unethical</u> is to treat one infectious disease differently from others! HIV is a deadly infectious disease and must be treated as such. It is not a passport to special privileges!

> "2. Dental Care for HIV-positive patients can be performed in the private practice setting using universal precautions and medical consultations as necessary."

This statement is patently false! The studies necessary to prove this have <u>never</u> been made. How meaningful are "medical consultations" when the necessary studies have never been made? In fact all evidence to date points to the exact opposite. The oral surgeons have never been able to protect themselves from HBV by "universal precautions." Even the C.D.C. estimates that there are about three times as many dentists HIV+ than surgeons! (Yes, I know that HBV is <u>supposed</u> to be more infectious than HIV. But let me ask you

this; "Are tens of thousands in this country and millions worldwide dying of HBV or AIDS?)

> "3. Information regarding the patient's disease status should be confidential. If it is deemed necessary to advise other health care providers, the patient's consent should be obtained."

This statement is at once unethical and also in direct opposition to statement number two. How would a dentist have "medical consultations" if he was not allowed to discuss a patient's HIV+/AIDS status? Is it ethical for a general dentist to refer a HIV+/AIDS patient to, for example, an oral surgeon or a periodontist without advising of the HIV+/AIDS status? Would the reverse be ethical?

> "We strongly believe that all patients, including those HIV-positive, have the right to go to the dentist of their choice for treatment. In addition, we feel that an equitable policy needs to incorporate some means for sharing responsibility for treating HIV-positive patients among all practicing dentists in the state. To this end, our committee proposes the following method for insuring access to care for HIV-Positive Patients:"

Again who are "we"! I do not believe that there is a single dentist in the country who has not refused treatment to at least several patients for good reasons. Nobody has completely free choice of either health care facility or provider. An expectant woman in the Bangor area has a choice of only one hospital if she wants an area obstetrician. Furthermore, if she delivers or needs a c-section on the weekend she gets whoever is doing rotation that weekend. She has no choice! When my wife and I moved to Bangor she was seven months pregnant with our daughter. No obstetrician in the area would take her on as a patient! We ended up with a G.P. who had been rehabilitated from drug abuse. (I am not complaining. He did a good professional job. I am just pointing out that my wife had no choice!) Why should persons infected with not only HIV but also a multitude of other infectious diseases have special privileges that even pregnant women are not entitled to?

The law for the practice of dentistry has always been one of mutual consent. The patient freely agrees to be treated and the practitioner freely agrees to treat.

It is not a question of availability of dental care for HIV+/AIDS persons. There are dentists and specialists who are willing to treat them. HIV+/AIDS persons comprise less than 0.3% of the population of the state. Clearly, only a small percentage of the dentists in the state are needed to treat them. Why should 100% of the Maine dental offices be exposed to the danger of an epidemic deadly infectious disease to accommodate 0.3% of the population. The 99.7% HIV free deserve and need protection from infectious disease too.

> "1. Patients of record remain with their dentist."

No one is recommending the abandonment of patients. However, the medical or emotional or infectious status of a patient may change. As a result, a dentist may not feel that he/she can safely of (sic) adequately treat that patient. This may require the dentist to refer the patient elsewhere. For example, I personally feel that HIV+/AIDS patients should be treated in a hospital environment. I do not feel that a private dental operatory can compare to a hospital operatory.

> "2. Patients of record referred to a specialty practice retain the referring dentist as their primary care provider."

This takes away the right of a dentist to decline to continue to be a primary care provider when he/she does not feel that it can be safely done. The rest of the dentist's patients have rights, too.

> "3. Patients without a dentist of record are encouraged to have their caseworker or physician contact the Maine Dental Association to obtain a dental care provider.

There is nothing wrong with the M.D.A. helping find practitioners who want to freely accept certain patients. However, my being taken to task for not <u>wanting to treat a mentally ill AIDS patient</u> proves that you cannot imagine a situation severe enough that they would not want to force you to

treat against your best judgment.

> "We suggest that the Maine Dental Association provide at least two choices from a list of dentists, by town, published by the Maine State Board of Dental Examiners.
>
> "1. If possible, dentists will be chosen from the patient's home town in alphabetical order, rotating down the listing, or, when indicated:
>
> "2. From a list of adjacent community dentists chosen on a similar fashion."

This completely takes away the right of a dentist to chose (sic) who he/she is willing to treat. It takes away your right to take what measures you deem prudent to protect your patients, staff, and family from infectious diseases. The M.D.A. or A.D.A. will not rush in and make everything better if you have major problems as a result of following their "AIDS Access Policy." If you do not believe me, just write either the M.D.A. or the A.D.A. and ask them for a written statement that they will accept all responsibility for any malpractice suits that <u>might arise from following their Recommended Policies to the letter</u>. For example, suppose a mentally ill AIDS patient bites a staff member or patient. Do you really think the M.D.A. will rush in and make everything better? I have my doubts.

> "The M.D.A. Central office will record all referrals and complaints regarding access. Dentists will be responsible for reporting the date of the initial appointment and the outcome (kept or failed) to the M.D.A. Central Office. Complaints will be directed to the appropriate committee for investigation and resolution. Unresolved complaints will be forwarded to the Maine State Board of Dental Examiners."

This paragraph in effect makes the M.D.A. Executive Council presenting itself as the "Ethics Committee" an <u>administrative court for enforcing the "Recommended M.D.A. AIDS Access Policy"</u>! If you have any doubt about this read the enclosed correspondence of the M.D.A. Executive Council calling itself the "Ethics Committee" persecuting me for "not wanting the (sic) treat a <u>mentally ill Aids patient</u>" and my policy

of not treating infectious diseases. In reading this correspondence you will see that the "Ethics Committee" can operate rather unprofessionally. There is a salient point that must be understood in the action that the "Ethics Committee" took against me. <u>There was no complaint from BMHI</u>. BMHI has known and respected my policy of not treating infectious patients for twelve years! BMHI did call and ask my receptionist if I "<u>would want to treat mentally ill AIDS patients</u>." (There are probably not ten other dentists in the state who could make a stronger case that they do not discriminate against the handicapped.) I have treated hundreds of mentally handicapped patients. I have never had any complaint from BMHI in quality of care. Nor has BMHI had any objections to my infectious disease policy. Superintendent H. Lawrence Ventura reconfirmed on March 21, 1991, that <u>BMHI had respected my infectious disease policy for twelve years and has no problem with continuing that policy</u>. Please consider the impossibility of treating to the complete satisfaction of those you are serving and having a <u>third party able</u> to made (sic) a complaint! We do not need an administrative court in the M.D.A!

I feel strongly that the Recommended M.D.A. Access Policy is ill conceived and would be detrimental to the dental profession.

RECOMMENDED MDA AIDS ACCESS POLICY

The MDA concurs with the American Dental Association regarding the treatment of HIV-infected patients:

1. It is unethical for us to refuse to treat a patient who is HIV-positive, based solely upon this diagnosis.
2. Dental Care for HIV-positive patients can be performed in the private practice setting using universal precautions and medical consultations as necessary.
3. Information regarding the patient's disease status should be kept confidential. If it is deemed necessary to advise other health care providers, the patient's consent should be

obtained.

We strongly believe that all patients, including those HIV-positive, have the right to go to the dentist of their choice for treatment. In addition, we feel that an equitable policy needs to incorporate some means for sharing responsibility for treating HIV-positive patients among all practicing dentists in the state. To this end, our committee proposes the following method for insuring access to care for HIV-Positive Patients:

1. Patients of record remain with their dentist.
2. Patients of record referred to a specialty practice retain the referring dentist as their primary care provider.
3. Patients without a dentist of record* are encouraged to have their caseworker or physician contact the Maine Dental Association to obtain a dental care provider.

We suggest that the Maine Dental Association provide at least two choices from a list of dentists, by town, published by the Maine State Board of Dental Examiners.

1. If possible, dentists will be chosen from the patient's home town in alphabetical order, rotating down the listing, or, when indicated:
2. From a list of adjacent community dentists chosen on a similar fashion.

The MDA Central office will record all referrals and complaints regarding access. Dentists will be responsible for reporting the date of the initial appointment and the outcome (kept or failed) to the MDA Central Office. Complaints will be directed to the appropriate committee for investigation and resolution. Unresolved complaints will be forwarded to the Maine State Board of Dental Examiners.

*Dentist of record is defined as one who provided a continuity of care over the last calendar year, including complete examination, charting, and treatment planning, not just emergency care.

Ed. Note: This policy will be presented to the membership on June 21st at the MDA Annual Meeting.

Removing the Rhetoric and Exposing the Grim Reality, Aids and Dentistry

Randon Bragdon, D.M.D.

The purpose of the following comments is to remove the rhetoric that has been concealing the grim reality of AIDS which is on a collision course with the dental profession.

We often hear the rhetoric that it is embarrassing that HIV+/AIDS individuals cannot get into any dental office they wish. There are serious consequences to being infectious with a deadly disease for which there is no known cure nor is one expected. What is truly embarrassing is that there is not more being done to protect the 99+% part of the public. Also, it is truly embarrassing that it was a twenty-two year old girl who first proved that HIV could be transmitted from dentist to patient. Why was it not first proven in either the dental or medical profession? That is embarrassing. It is embarrassing that national infection control standards are being made and enforced by OSHA. It is a sad commentary that the A.M.A./A.D.A. has not been in such a bastion of infection control that OSHA could not infringe on that turf. After all, OSHA also sets the standards for handling concrete. Yes, there are a lot of embarrassing things. But the fact that there are unpleasant consequences to contracting a deadly disease is not embarrassing—it is tragic and unfortunate.

"HIV infection can be controlled by education and safe sex."

We have concluded a ten year test of these two fallacies. In 1981, the first case of AIDS was diagnosed. That year there were only a handful of cases. Over 650 of the early cases were traced to so called "patient zero," a homosexual airline steward. The first proven case of AIDS was a homosexual sailor who died of AIDS in England in 1959. This case was reported in Lancet, October 29, 1960, as a puzzling case. It was proven to be AIDS from saved tissue last year. AIDS has a long latency. It was stated at the 1991 Yankee Dental Congress that the majority of the AIDS cases of the 90's were contracted in the 70's. "In a follow up study of a segment of 6,875 San Francisco

homosexual men seen at a clinic between 1978 and 1980, the number testing positive for AIDS infection increased from a modest 4.5 percent in 1978 to an epidemic level of 74.5 percent in 1985." (H.W. Jaffe et al., Ann of Int Med 1985; 103:210-214.) The homosexual subculture has saturated itself with HIV infection. The new HIV infections in homosexuals mostly reflect recruitment. Even the incidence of syphilis and gonorrhea in homosexuals is about twice as great as it was ten years ago! So much for education! There is no such thing as "safe sex". It does not prevent pregnancy much less infectious disease. One of the most vocal nationally known instructors in "safe sex" was diagnosed as having AIDS recently. Apparently taking his own advise did not work very well.

If we go through the 90's with the same cavalier attitude that we went through the 80's with, our society will be hopelessly diseased.

The N.Y. medical delivery system is fast being overwhelmed by AIDS. In some N.Y. hospitals nurses are being paid over $70K per year, up from $22.5K about four years ago. Even at over $70K per year, most American nurses will not work in N.Y. hospitals. Many of the nurses are from Mexico and the Philippines.

The "experts" that are telling us that there is no transmission of HIV in dentistry do not have a good track record. They are the same ones who said that only 10% of the HIV+ would die of AIDS. In 1982, they said you could not get HIV from blood! The CDC authored the "swine flu epidemic and vaccine" debacle. A vaccine that paralyzed over 1,000 for a epidemic that never existed! At the January '91 Yankee Dental Congress, we were told by one "expert" that a "drop of HIV+ blood on your clothing, hair, or skin" from a patient would be noninfectious "the moment it dried". From this ludicrous statement you might conclude that blow dryers should be a part of "universal precautions"!

Over 75% of AIDS patients have dementia. In fact this is often the only manifestation of the disease. AS a result they cannot be expected to act and think completely normally.

It is a myth that dental workers have nothing to fear if they observe "universal precautions". We make wide use of sharp instruments and needles. Who has not looked at his/her gloves and seen holes "that were not there before!" I think there has been a lot of confusing of good luck with good judgment.

I would like to quote James Tusky, M.D. chief resident at a California hospital, who said he spent years denying the risk of HIV infection to doctors. Then in his third year he stuck himself with a needle he had just withdrawn from a male AIDS patient.

> "My world changed. The feeling you get looking down and seeing blood oozing out of your finger is one that I hope no one here will ever have. It changed my life. It changed my sex life."
>
> James Tusky, M.D.

A recent survey of internal medicine residents and internists at the three teaching hospitals in San Francisco revealed that 55% had been stuck by needles known to be withdrawn from AIDS patients. Where is the compassion for the innocently infected healthcare workers?

It is a proven fact that coughed aerosols containing TB and HIV remain viable for up to a week. It requires a leap of faith to believe that a aerosol particle containing enough TB bacteria to infect would not contain enough HIV virons to infect.

In vitro HIV infection by handpiece aerosols is now a proven fact.

The fact that HIV+/AIDS persons carry a number of other diseases cannot be ignored. What if a HIV+/AIDS patient in your office transmits CMV to another pregnant patient or staff member? The baby may either be horribly deformed or die! Who will be sued? Suppose that a HIV+/AIDS patient has a "conservative treatment"—e.g. a prophy and scaling. It would not be surprising that the patient's gingiva would bleed freely. After the dental treatment the patient goes into the bathroom and spits all over the sink and/or toilet because he/she does not

like the taste of blood. He/She then wipes his/her mouth with his/her hand. Then touches the flush handle, the bathroom doorknob and the front door doorknob of your office. Then a child or adult with a open lesion on their hand touches the front door doorknob, the bathroom doorknob, and the flush handle. This is to say nothing about the possible condition of the sink and toilet!

TB is increasing greatly. Transmission requires only a common ventilation system. The patient that contracts TB does not even have to be in the same room the same day! With DNA sequencing the malpractice lawyer will be able to prove that their client's TB bacillus came from a HIV+/AIDS patient that was in your office. HE/She will be further able to prove that your office was the only closed ventilation system the client and the HIV+/AIDS TB carrier had in common.

There is a big difference in liability between knowingly exposing patients to infectious disease and unknowingly exposing patients. This makes the argument we should knowingly treat HIV+/AIDS patients because we may have unknowingly treated completely fallacious.

Remember when the AIDS patients first began to pour into San Francisco and Los Angelos (sic) hospitals? Nurses were forbidden to wear gloves because AIDS homosexuals were offended that nurses "did not want to touch their bare skin with their bare hands." To forbid the donning of gloves was unreasonable then and absurd in retrospect. These are the same activists who are trying to tell us how to control infection in our offices today.

Some experts told dentists in the past that washing gloves was an acceptable practice. It is now well accepted that gloves should be changed and not washed. Were those of us who have always changed gloves at fault in the past?

The experts used to tell us to cut needles. Now we are told not to "because it splatters blood." The splatter caused by cutting needles is nothing compared to the splatter that occurs during many dental procedures.

The transmission of infectious disease is more complex than the present state of our understanding. One surgeon with HBV was permitted to practice with patient's informed consent by double gloves and other extraordinary precautions. Within six months he had a proven HBV transmission to a women (sic) for whom he had done a c-section. The mode of transmission is still not understood.

What are the consequences of overreacting to the threat of infectious disease versus under-reacting? Overreacting is, I believe, the safer course. Because the homosexual subculture has generally accepted the rhetoric instead of the reality of the HIV/AIDS danger, they are almost all infected. If the homosexual subculture had adopted a lifesaving fear of contracting HIV/AIDS, this country would not be confronted with the reality of the present AIDs epidemic.

We may not be able to set everything right in this world, but we should be free to set our own offices as right as possible.

Declaration of Deborah Greenspan, BDS, DSc, ScD (hc), FDS RCSEd (Hon)

Executed on September 17, 1995

(Caption Omitted in Printing)

Pursuant to 28 U.S.C. § 1746, I Deborah Greenspan, BDS, DSc, ScD (hc), FDS RCSEd (hon) declare that:

I hold a Bachelor of Dental Surgery and a Doctor of Science in oral medicine from the University of London, England, an honorary Doctor of Science from Georgetown University, Washington, D.C., and an honorary Fellowship in Dental Surgery from the Royal College of Surgeons at Edinburgh. I am currently Clinical Professor or Oral Medicine at the University of California at San Francisco and am also Chair of the committee on Infection Control and Compliance at the UCSF School of Dentistry. At the dental school, I have treated over one thousand patients who are HIV-positive. In addition, I have supervised many dental students and residents, who routinely treat HIV-positive patients in the dental clinic and use the same infection control procedures as can and should be used in a private dental office.

I have written and lectured extensively on HIV and the practice of dentistry. My education, professional experience, and publications are more fully set forth on my Curriculum Vitae, attached hereto.

I have read the following documents generated in this case:

A. Expert Report of Randon Bragdon, DMD

B. Infectious Disease Policy of Randon Bragdon, DMD

C. Expert Report of Sanford Kuvin, MS, MD, DTM & H

D. Expert Report of Deborah Greenspan, BDS, DSc

E. Expert Report of John Molinari, PhD

F. Expert Report of Donald Craven, MD

G. Deposition of Randon Bragdon, DMD

In addition, I have read the deposition of Randon Bragdon, D.M.D., as well as the exhibits attached thereto, in the case known as John Doe v. Bragdon, C.A. No. CV-93-63 (Me. Sup. Ct.).

Based on my education, experience and expertise I offer the following opinions in this case:

1. HIV is a retrovirus and is the causative agent of the Acquired Immune Deficiency Syndrome ("AIDS").

2. Persons exposed to HIV may contract the virus, and, after a period of one to at most six months, will develop HIV antibodies, thus becoming HIV-seropositive. The collection of symptoms that characterizes AIDS may not appear for seven to ten years after seroconversion. During much of this period, persons who are HIV-positive may be asymptomatic but are infectious.

3. As HIV infection progressive to AIDS, immunodeficiency develops. AIDS is characterized by severe opportunistic infections or malignancies arising with progressive compromise of the immune system.

4. Persons with HIV and persons with AIDS have a continuing need for routine dental services such as those provided by general dentists like Dr. Bragdon.

5. HIV is transmitted through (1) sexual contact with exchange of body fluids with an infected person, (2) invasive exposure to infected blood or blood components, and (3) perinatally from mother to neonate. HIV is not an airborne pathogen and there is no evidence to suggest that it can be transmitted by aerosols in the dental office. Sexual contact with exchange of body fluids constitutes the major risk factor for transmitting or contracting HIV infection. Intravenous drug use with shared needles is also a major risk factor.

6. In the 14 years since AIDS was first recognized, there has been not one documented case of transmission of HIV in the dental health care setting from infected patient to dental health care worker. Similarly, there has been not one documented case of transmission of HIV from infected patient to another patient in the dental setting. This epidemiological evidence clearly demonstrates that it is safe to treat persons with HIV/AIDS in the private dental office setting.

7. In 1986 the Centers for Disease Control and Prevention ("CDC") issued Recommended Infection-Control Practices for Dentistry. In 1987 the CED issued Recommendations for the Prevention of HIV Transmission in Health-Care Settings, including dentistry. In 1991 the Occupational Safety and Health Administration ("OSHA") issued its final rule on Occupational Exposure to Bloodborne Pathogens, which protects, among other persons, all dental employees. In 1993 the CDC issued revised Recommended Infection-Control Practices for Dentistry.

8. All of the above guidance recommends the use of "universal precautions" – infection control procedures wherein each patient is treated as if infectious for HIV, Hepatitis B, and other bloodborne pathogens. Universal precautions must be utilized in the dental setting because dental health care workers have no way of knowing whether or not the patient that they are treating is infectious. So long as universal precautions are used, HIV-positive patients may be safely treated in the private dental office.

9. In the dental setting, universal precautions include the use of protective attire, such as gloves, gowns, protective eyewear, surgical masks, and/or face shields; proper sterilization of all dental instruments, including the autoclaving of dental handpieces after each use; and proper disinfection of the dental unit and operatory surfaces.

10. No additional infection control procedures – above and beyond universal precautions – are required to provide dental treatment to persons with HIV infection or AIDS. There is no need for any of the additional procedures outlined in Dr. Bragdon's expert report, other than those already recommended

by the CDC and OSHA.

11. There is no medical or scientific basis whatsoever for Dr. Bragdon's infectious disease policy. The entire premise underlying universal precautions is that all patients should be treated as potentially infectious for HIV, Hepatitis B, Hepatitis C, and other bloodborne pathogens.

12. Indeed, the entire purpose of universal precautions is to obviate any need for an infectious disease policy such as Dr. Bragdon's. The use of such a policy is neither appropriate nor necessary in any dental setting, including a private dental office.

13. With respect to the issue of infection control, there is no difference in treating a dental patient in a dental school clinic, a hospital setting, or a private dental office. Universal precautions should be universally employed when treating a dental patient, regardless of the treatment environment. So long as such precautions are properly utilized, it is just as safe to treat a patient in a private dental office as it is to treat a patient in a hospital setting.

14. To the extent that there have been cases of occupationally acquired HIV in the health care setting, the transmissions have resulted not from the failure of universal precautions, but rather, from accidental injuries (e.g., accidentally being stuck with a contaminated needle). There is no evidence that providing dental treatment to a person with HIV in a hospital operatory in any way reduces the risk of accidental injuries. In fact, the majority of accidental injuries resulting in occupationally acquired HIV have occurred in the hospital setting.

15. No special training or expertise, other than that possessed by a general dentist, is required to provide general dental care – including basic restorative dentistry, such as the filling of a cavity – to persons with HIV infection or AIDS. No such specialty is recognized by the dental profession.

16. While it is true that some persons with HIV might require specialized care for a particular oral condition – for example, hairy leukoplakia or a severe periodontal condition –

the patient should be referred by their general dentist to a specialist only for the particular treatment required. When such a referral is made, the patient is expected to return to the general dentist for the provision of subsequent routine dental care.

17. In 1988, the American Dental Association's House of Delegates adopted its current policy on the treatment of persons with HIV or AIDS. The policy states, among other things:

> The Association believes that HIV-infected individuals should be treated with compassion and dignity. Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.
>
> A sound approach to the treatment of infectious patients requires an assessment of the patient's condition based on reasonable and informed medical judgments, given the state of medical knowledge at the time. A dentist should not refuse to treat a patient whose condition is within the dentist's current realm of competence solely because the patient is HIV-infected.

American Dental Association, 132nd Annual Session 539 (1991).

18. Dr. Bragdon's position that he will only treat persons with HIV/AIDS in a hospital setting is in direct contravention of the American Dental Association's policies, and, as a dentist, I therefore believe that they constitute a breach of his professional obligations.

19. There is no medical or scientific justification for Dr. Bragdon's refusal to treat Sidney Abbott in his dental office. Dr. Bragdon's refusal to treat Sidney Abbott is in direct contravention of the American Dental Association's policies.

20. To the extent that Dr. Bragdon's refusal to treat HIV-positive persons in his office is based on his concern that such persons might be infectious for tuberculosis (TB), Dr. Bragdon's position has no merit. Most people with infectious TB are not HIV-positive. Although it is true that HIV-positive persons are at a higher risk for progression from latent TB infection to active disease than the general population, this is true for many other populations as well (e.g., children less than four years of age, the elderly, individuals with chronic renal failure with renal dialysis, individuals with diabetes mellitus, and individuals who are immunocompromised, such as those undergoing chemotherapy).

21. If a dental patient is known or believed to be infectious for TB, dental treatment should be postponed until the person has been evaluated, and, if infectious for TB, until the person no longer is infectious. (If emergency treatment is required – e.g., if the patient has a life threatening dental condition – then the patient would need to be seen in an appropriate specialized setting.) Postponing dental treatment or treating in a specialized setting because the patient has TB, regardless of the person's HIV status, is a separate and distinct issue from refusing to provide dental care in a private dental office solely because a person has HIV/AIDS. There is no medical or scientific basis for denying dental care on the basis of a person's HIV status alone.

22. While it is true that HIV and Hepatitis B (HBV) are both bloodborne pathogens, HBV is a significantly more infectious and more easily transmitted virus than HIV.

23. As health care workers, we must base our policies, practices, and procedures on current scientific knowledge.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

/s/ Dr. Deborah Greenspan
University of California at San Francisco
School of Dentistry
513 Parnasus Ave., Box 0442, S-612
San Francisco, CA 94143

University of California, San Francisco

CURRICULUM VITAE
Prepared May 2, 1995

NAME: Deborah Greenspan

CURRENT TITLE AND DEPARTMENT:

Clinical Professor of Oral Medicine
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EDUCATION:

Dates Attended: 1958-60

Institution and Location:

Royal Free Hospital
School of Medicine
University of London, England

Degrees Conferred, Title or Status: 2nd BDS

Major Subject: Basic Sciences

Dates Attended: 1960-64

Institution and Location:

Royal Dental Hospital of London,

School of Dental Surgery, University
of London, England

Degrees Conferred, Title or Status: BDS

Major subject: Dentistry

Dates Attended: 1964

Institution and Location:

Royal College of Surgeons,
England

Degrees Conferred, Title or Status: LDS RCS

Major subject: Dentistry

Dates Attended: 1976-78

Institution and Location:

University of California, San Francisco,
Department of Oral Medicine and Hospital
Dentistry

Degrees Conferred, Title or Status: Fellow

Major subject: Oral Medicine

Dates Attended: 1991

Institution and Location:

University of London, England

Degrees Conferred, Title or Status: DSc (Med)

Major subject: Oral Medicine

LICENSES, CERTIFICATIONS, ETC.:

1964	Royal College of Surgeons of England, Licentiate in Dental Surgery
1964	Registered Dental Practitioner, United Kingdom
1977	National Board of Dental Examiners, Parts I and II
1978	Certificate in Oral Medicine

BOARD CERTIFICATION:

1985	Diplomate, American Board of Oral Medicine

PRINCIPAL POSITIONS HELD:

1964-65	Dental Group Practice, Wembley, England - Associate
1965-76	Private Practice and National Health Service - Dentist (Owner and director of two general dental practices employing three dentists and five staff personnel)
1972	University of California, San Francisco - Lecturer in Oral Biology
1976-83	University of California, San Francisco - Visiting Lecturer in Oral Medicine
1983-85	University of California, San Francisco - Assistant Clinical Professor of Oral Medicine
1985-1989	University of California, San Francisco - Associate Clinical Professor of Oral Medicine
1989-now	University of California, San Francisco - Clinical Professor of Oral Medicine

ANCILLARY POSITIONS HELD:

1987-now	Clinical Director, UCSF Oral AIDS Center

HONORS AND AWARDS:

1978-79	Fellow of National Cancer Institute, Department of Oral Medicine and Hospital Dentistry, University of California, San Francisco
1984-now	Faculty Member, Rho Rho Chapter, Omicron Kappa Upsilon, Dental Honor Society

1986	Award for Teaching Excellence in Oral Medicine from Class of 1987
1986	Woman of Distinction Award, London, UK
1988	Fellow, American College of Dentists
1988	Annenberg Lecture. Alpha Omega Dental Society. London, England.
1989	Samuel Charles Miller Award, American Academy of Oral Medicine
1989	Seymour J. Kreshover Lecture, National Institute of Dental Research
1989	Assistant Secretary for Health, Certificate of Commendation
1990	ScD(hc). Honorary Degree, Doctor of Science, Georgetown University, Washington DC
1991-now	Honorary Lecturer, United Medical and Dental Schools of Guys and St. Thomas Hospitals, University of London, England
1991	Honorary Visiting Professor, Faculty of Dentistry, University of Queensland, Brisbane, Australia
1992	Nevin Lecture. University of Colorado, Denver, Colorado
1992	Commencement Speaker, Eastman Dental Center, Rochester, New York
1993-now	Who's Who in America
1993	Fellow, Pierre Fauchard Academy
1993	Fellow of the American Association for the Advancement of Science
1994	Distinguished Visiting Professor, Beth Israel Medical Center, New York
1994	FDS RCSEd, Honorary Fellowship in Dental Surgery, Royal College of Surgeons
1994-now	Dictionary of International Biography

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS:

1964-76	Royal Society of Medicine, London (Associate)
1960-79	British Dental Association
1979-now	International Association for Dental Research
1979-now	American Association for Dental Research
1979-now	American Academy of Oral Pathology
1983-now	American Society of Microbiology
1983	American Society for Cancer Chemotherapy

1985-now	American Association of Women Dentists
1986-now	American Association for the Advancement of Science
1986-now	American Academy of Oral Medicine
1986-now	American Association of Dental Schools
1986-now	International Association of Oral Pathologists
1986-now	American Dental Association
1986-now	California Dental Association
1986-now	San Francisco Dental Society
1987-now	Royal Society of Medicine, London (Fellow)
1988-now	International AIDS Society
1992-now	American Public Health Association

SERVICE TO PROFESSIONAL ORGANIZATIONS:

1986-87	IADR/AADR, Experimental Pathology Group, Member at Large, Executive Committee
1986-89	AADR, Session Chairman
1987	IADR/AADR, Moderator, symposium on Smokeless Tobacco, Chicago, Illinois
1987	American Medical Association, AIDS and Public Policy. Chicago, Illinois
1987	Testifying before a Joint Sub-committee of California Legislature on Health Effects of Tobacco representing California Dental Association, Sacramento, California
1988	IADR/AADR, Organizer and Moderator, Symposium on Papillomaviruses, Montreal, Canada
1988-89	IADR/AADR, Experimental Pathology Group. Program Chair
1988-91	AADR, Constitution Committee, Member. Chair 1990-91
1988-now	American Dental Association. Visiting Lecturer, Speaker's Bureau
1988	Testifying before the House Appropriations Committee, Sub-Committee on Labor, Health and Human Services and Education, representing the American Association of Dental Research, Washington, D.C.
1988-now	American Dental Association, Consultant, Council on Dental Therapeutics

1989-90	Vlth International Conference on AIDS 1990. Planning Committee Track 11, Clinical Sciences
1989	National AIDS Update 1989. Advisory Committee
1989	AIDS and Dental Education. Symposium participant. American Association of Dental Schools, San Francisco, California
1988-89	IADR/AADR, Experimental Pathology Group, President-Elect
1989-90	IADR/AADR, Experimental Pathology Group, President, Executive Committee
1989	Committee on Curriculum Guidelines for Infectious Diseases American Association of Dental Schools, Centers for Disease Control, HRSA, Washington, DC
1990	Testifying before the Human Resources Task Force, Committee on the Budget, House of Representatives; representing the American Association of Dental Schools, San Francisco, California
1990	Occupational Hazards in Dentistry: Risk, Perception and Response. Participant, Joint AADR/AADS Symposium, Cincinnati, Ohio
1990	Opportunities in Science, Careers in Dental Science. Participant, IADR/AADR Symposium, Cincinnati, Ohio
1990-1	AADR, San Francisco Section, President
1991-1994	AADR, Treasurer
1991	IADR/AADR Oral Infections In The Immunocompromised Host. Co-Chair, Symposium, Acapulco, Mexico
1991	IADR/AADR, Dental Implications of AIDS. Science Transfer Seminar, Acapulco, Mexico
1991	Australia and New Zealand Division IADR. Impact of the AIDS Epidemic on the Dental Profession. Symposium participant, Brisbane, Australia
1991	Australia and New Zealand Division IADR. Session Chair, Brisbane, Australia
1992	AADR. Oral Opportunistic Infections in HIV disease. Science Transfer Seminar. Boston, Massachusetts

1992 Opportunities in Science Careers in Dental Science. Participant in AADR Outreach Symposium. Boston, Massachusetts

1992 International Congress on Oral Medicine, Session Chair. Edinburgh, Scotland

1992 Ad hoc reviewer: Grants and Allocation Committee, American Fund for Dental Health

1993 Testifying before the House Appropriations Committee, Sub-Committee on Labor, Health and Human Services and Education, representing the American Association of Dental Schools, Washington, DC

1993 Opportunities in Science Careers in Dental Science. Participant in AADR Outreach Symposium. Chicago, Illinois

1993 Oral Candidiasis: Clinical implications, pathogenesis and therapy. Co-Chair IADR/AADR Symposium, Chicago, Illinois

1993 Testifying before the Institute of Medicine, Committee on the Future of Dental Education, Washington, DC

1994-5 Immediate Past Treasurer, American Association for Dental Research

1994-5 Member, Organizing Committee International Conference on Oral Biology, IADR

1995 Distinguished Speaker. Student Research Group Meeting. American Association for Dental Research, San Antonio, Texas

1995 AIDS Dental Reimbursement. Symposium Moderator. American Association of Dental Schools, San Antonio, Texas

SERVICE TO PROFESSIONAL PUBLICATIONS:

1983-88 Journal of Oral Pathology - Ad Hoc Referee

1985-now Cancer - Ad Hoc Referee

1986-now Journal of the Academy of General Dentistry - Ad Hoc Referee

1986 European Journal of Cancer & Clinical Oncology - Ad Hoc Referee

1988-now Archives of Dermatology - Ad Hoc Referee

1988-now Journal of the American Medical Association - Ad Hoc Referee

1991-now AIDS - Ad Hoc Referee

1991-now Journal of Acquired Immunodeficiency Syndrome - Ad Hoc Referee

1991-1994 Journal of The American College of Dentists - Editorial Board of Review

1991-now Journal of Dental Research - Ad Hoc Referee

1991-now Journal of the American Dental Association - Ad Hoc Referee

1992 Community Dentistry and Oral Epidemiology - Ad Hoc Referee

1992-now Journal of the California Dental Association - Ad Hoc Referee

1992 Journal of Oral Pathology and Medicine - Ad Hoc Referee

1993-now Journal of Oral Pathology and Medicine - Editorial Board of Review

1993-4 Special Care in Dentistry - Ad Hoc Referee

1994 New England Journal of Medicine - Ad Hoc Referee

SERVICE TO GOVERNMENT:

1987 Consultant for Review of Guidelines for Prevention of Transmission of HIV Infection in Health Care Workers (two meetings). Centers for Disease Control, Atlanta, Georgia

1987,88 Consultant; NIDR AIDS Task Force. NIDR, Washington, DC

1987 Consultant; Task Force on AIDS and Dental Education. AADS, CDC and HRSA. Washington, DC

1987-now Ad Hoc reviewer for ROI applications. Epidemiology and Disease Control Study Section, Division of Research Grants, NIH

1988 Consultant; Multidisciplinary Curriculum Development Conference on HIV Infection. Workshop Leader: Provider Responsibility: Legal and Ethical Issues. Bureau of Maternal and Child Health and Resources Development. HRSA. Baltimore, Maryland

1988 Member of Objective review Committee, AIDS

Regional Education and Training Centers. Bureau of Maternal and Child Health and Resources Development. HRSA. Rockville, Maryland

1989 Speaker: NIH Consensus Development Conference. Oral complications of cancer therapies: Diagnosis, prevention and treatment

1989 Member: Ad hoc committee on smoking cessation in the dental office. National Cancer Institute, Rockville, Maryland

1989-now Member: Programs Advisory Committee of the National Institute of Dental Research

1989 Participant: HIV/AIDS Surveillance and Epidemiology Briefing. WHO/GPA. Berkeley, California

1990 Consultant: NIDR HIV Oral Health Research Activity at The Walter Reed Army Medical Center, Washington, DC

1990 Member: Special ad hoc Review Committee for Program Project application. NIDR

1991-1993 Member: National Panel for The Development of Clinical Practice Guidelines for HIV and AIDS. Agency for Health Care Policy and Research

1991-1994 Member: Dental Products Panel, Center for Devices and Radiological Health, Food and Drug Administration

1991 Member: Special ad hoc Technical Review Panel. NIDR

1992 Ad hoc reviewer: Small Grants Review Committee. NIDR

1992 Ad hoc reviewer: Small Grants Application Agency for Health Care Policy and Research

1993 Ad hoc reviewer: Small Grants Review Committee. NIDR

1994 Member: Workshop for strategic planning. Office of AIDS Research. Washington, DC

1994 Consultant: Dental Products Panel, Center for Devices and Radiological Health, Food and Drug Administration

CONSULTANT:

1986 Consultant to the Working Party on AIDS,

European Economic Community Bureau of Health, Copenhagen, Denmark

1987 AIDS Services Evaluation Project. Northwestern University Dental School, Chicago, Illinois

1988 AHEC. Train-the-Trainer program, UCSF

1989 Oral AIDS Project, Louisiana State University Medical Center1989-94

1989-94 Joint FDI/WHO working group on AIDS

1989 Reviewer: Medical Research Council, United Kingdom

1990 Consultant: European Economic Community Clearinghouse on Oral Problems Related to HIV Infection and World Health Organization Collaborating Center on Oral Manifestations of HIV infection, Amsterdam, Holland

1991 Consultant: Panel on Guidelines for the Infected Health Care Worker; Dept. of Health, State of California, representing the California Dental Association

1991 Consultant: Prevention of HIV and Hepatitis B in The Health Care Setting World Health Organization, Geneva, Switzerland

1991 Consultant: AIDS Task Force, San Francisco Medical Society

1992 Consultant: European Economic Community Clearinghouse on Oral Problems Related to HIV Infection and World Health Organization Collaborating Center on Oral Manifestations of HIV Infection, London, England

[Scientific Papers and Presentations Omitted from Appendix]

Declaration of Donald Wayne Marianos, D.D.S., M.P.H.

Executed on September 18, 1995

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.H., M.P.H. declare that:

I hold a Masters in Public Health from Loma Linda University and a Doctor of Dental Surgery from the Indiana University School of Dentistry. From August 1989 to the present I have served as Captain in the United States Public Health Service ("USPHS") at the Centers for Disease Control and Prevention ("CDC"). From 1992 to the present, I have served as the Director of the Division or Oral Health.

During my tenure at the CDC, I have provided technical assistance to international, federal, state and local health organizations in the area of infection control and infectious diseases in dentistry. I have served as dental consultant to the various CDC centers and institutes on issues related to HIV/AIDS and dentistry. In addition, I have coordinated epidemiologic investigations involving dental health care workers with HIV/AIDS as well as prevention of HIV/AIDS transmission in dental care settings. I have assisted in the development and dissemination of professional educational materials for dentists.

Prior to coming to the CDC, I was the Chief of Dental Services at the USPHS Indian Health Service Hospital in Whiteriver, Arizona from September 1979 to August 1989. There I was the senior administrator of the hospital dental program and community based preventive dentistry program. In that capacity, I treated approximately patients whom I knew to have HIV/AIDS. When treating these patients, I did not utilize any infection control procedures other than those recommended by the CDC.

My education and professional experience are more fully set forth in my curriculum vitae, attached hereto.

I have read the following documents generated in this case:

A. Expert Report of Randon Bragdon, DMD

B. Infectious Disease Policy of Randon Bragdon, DMD

C. Expert Report of Sanford Kuvin, MS, MD, DTM & H

D. Expert Report of Deborah Greenspan, BDS, DSc

E. Expert Report of John Molinari, PhD

F. Expert Report of Donald Craven, MD

G. Deposition of Randon Bragdon, DMD

Based upon my education, experience and expertise I offer the following opinions in this case:

1. The mission of the CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. As the United States' prevention agency, we accomplish our mission by working with our partners throughout the nation and the world to: monitor health problems; detect and investigate health problems; conduct research to enhance prevention; develop and advocate sound public health policies; implement prevention strategies; promote healthy behaviors; and foster safe and healthful environments.

2. The human immunodeficiency virus ("HIV") is a human retrovirus and is the causative agent of the Acquired Immunodeficiency Syndrome ("AIDS"). HIV infection is transmitted by sexual contact with an infected individual, exposure to infected blood or blood products, or perinatally from an infected mother to infant during pregnancy, birth, or breast feeding. In the 14 years since HIV was first recognized, our understanding of the modes of transmission of the virus have consistently demonstrated that casual contact has not been associated with transmission.

3. Over the years, the CDC has recommended the use of infection control procedures to protect the health and safety of

both health care workers and patients. Since medical history and examination cannot reliably identify all patients infected with HIV or other bloodborne pathogens, blood and body fluids precautions should be consistently used for all patients. This approach is referred to as "universal precautions" and should be used whenever infection control procedures are implemented.

4. In 1986 the CDC issued Recommended Infection Control Practices for Dentistry. The 1986 recommendations established a common set of infection control strategies for reducing the possibility of transmission of hepatitis B virus (HBV), HIV, and other bloodborne pathogens in the dental setting. They emphasized: the medical history; use of protective attire and barrier techniques; handwashing; use and care of sharp instruments; proper disinfection and sterilization of instruments; decontamination of environmental surfaces, supplies, and materials; use and care of dental handpieces; handling of biopsy specimens; and disposal of waste materials.

5. In 1987 the CDC issued Recommendations for the Prevention of HIV Transmission in Health Care Settings, including dentistry. The 1987 recommendations consolidated and updated previous CDC recommendations for preventing HIV transmission health care settings, as well as, precautions for clinical and laboratory staffs. The precautions for dentistry developed in 1986 were summarized.

6. In 1993, the CDC issued revised Recommended Infection Control Practices for Dentistry. The 1993 document updates previously published CDC recommendations for infection control practices in dentistry to reflect new data, materials, technology, and equipment. When implemented these recommendations reduce the risk of disease transmission in the dental environment, from patient to dental health-care worker (DHCW), from DHCW to patient, and from patient to patient. Based on principles of infection control, the document delineates specific recommendations related to vaccination of DHCWs; protective attire and barrier techniques; handwashing and care of hands; the use and care of sharp instruments and needles; sterilization or disinfection of instruments; cleaning and disinfection of the dental unit and environmental surfaces; disinfection and the dental laboratory; use and care of

handpieces, anti-retraction valves, and other intraoral dental devices attached to air and water lines of dental units; single-use disposable instruments; the handling of biopsy specimens; use of extracted teeth in dental educational settings; disposal of waste materials; and implementation of recommendations.

7. No infection control procedures beyond the use of universal precautions are necessary when providing routine dental care to persons with HIV and AIDSI. The CDC does not recommend the use of infection control procedures beyond those cited in the Recommended Infection Control for Dentistry, 1993 for the provision of routine dental treatment to persons with HIV or AIDS.

8. I do not know of any dental clinic or hospital that treats patients with HIV/AIDS that utilizes the procedures outlined in Bragdon's expert report. Indeed, in my experience, the vast majority of hospital dental operatories are not even equipped with the engineering controls (e.g., negative air pressure and ultraviolet lighting) that Bragdon maintains must be utilized before treating a patient with HIV/AIDS.

9. No special expertise beyond that of a general dentist is required to provide routine dental care to a person with HIV or AIDS.

10. If dentists, including general dentists such as Dr. Bragdon, follow universal precautions in their practice, persons with HIV or AIDS or other blood-borne pathogens can be safely treated in private dental offices.

11. If a dentist follows universal precautions – including, specifically, the heat sterilization of dental instruments and handpieces – there is virtually no risk of patient-to-patient transmission of HIV.

12. There is no medical or scientific basis for treating all HIV-positive dental patients in a hospital setting. With respect to the routine practice of dentistry, hospitals do not offer "superior" methods of infection control. So long as universal precautions are properly utilized, the risk of Hiv transmission from an infected patient to DHCW or from infected patient to

uninfected patient is not reduced by providing treatment in a hospital setting.

13. As of December 31, 1994, the last date for which I am aware of accurate statistics, CDC was aware of 42 health care workers in the United States who have been documented as having seroconverted to HIV following occupational exposures to HIV. None of these are dental workers.

14. 36 of the 42 occupational exposures to HIV were due to percutaneous exposures. Studies indicate that the quantity of inoculum (amount) of blood, as well as the titer (quantity of HIV in the blood) of infectious agent in the source blood are to be among factors associated with the risk of HIV transmission after percutaneous exposure to HIV-infected blood. In a case-control study, a larger quantity of blood transferred was represented by larger gauge of hollow-bore needles (<18 gauge), deep injury, and presence of visible blood contamination on the device. In dentistry, available information indicates that exposure to blood involves smaller rather than larger quantities of blood identified in the case control study. This may help explain the fact that there have been no documented cases of occupational transmission of HIV to DHCW's.

15. To the beset of my knowledge, there has never been an incidence of patient to patient transmission of any blood-borne pathogen in the dental setting.

16. Despite the fact that probably over one billion dental procedures have been performed by over 250,000 dental health care professionals in the past fourteen years, and despite the fact that approximately 1,000,000 individuals in the United States are estimated to be infected with HIV, there has never been a documented case of HIV transmission from infected patient to dental health care worker, nor from infected patient to non-infected patient.

17. As of January 1, 1995, information about investigations of 64 HCWs infected with HIV, including 29 dentists and 4 dental students, was reported to the CDC. Evaluations of over 22,000 patients of these HIV infected HCWs failed to detect

any transmission of HIV from HCW to patient. These data are consistent with previous assessments that the risk of transmission from a HCW to a patient is very small.

18. To date the only case of HIV transmission from a HCW to patient remains that of a Florida dentist who was found to have transmitted HIV to 6 of his patients. The specific mechanism of transmission has not been identified and it is unlikely to be identified in the future. To my knowledge, no studies have determined if these transmissions were accidental or intentional.

19. There are inherent risks associated with the practice of dentistry. Well before the advent of HIV, DHCW's were at risk of acquiring occupationally a number of diseases, from the common cold to potentially lethal Hepatitis B and TB.

20. For example, HBV is much more infectious than HIV, and many people who are infectious for HBV do not know that they are infectious. Approximately 200 HCWs, including dentists, die annually as a result of occupationally acquired HBV.

21. Given the demonstrated efficacy of universal precautions, Dr. Bragdon's Infectious Disease Policy is simply not grounded in current science as regards treatment of patients with HIV or other bloodborne pathogens.

I hereby delcare under penalty of perjury that the foregoing information is true tot he best of my knowledge and belief.

Exeduted on 9/18/95

/s/ Dr. Donald Wayne Marianos
Centers for Disease Control
MCPS/DDPA
1600 Clifton Road, N.E.
Mail Stop F-10
Atlanta, Georgia 30333

AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS POSITION PAPER ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Preface

The Association recognizes the need to address a variety of issues related to AIDS and Infectious Disease in the OMS office. During the past year, the membership has expressed a need for clarification regarding government regulations, infection control practice as well as ethical, legal, and political issues. In addition, the Committee on Federal Governmental Affairs recommended that the Board of Trustees authorize a position paper providing a response to proposed guidelines from the federal Centers for Disease Control (CDC). At its June meeting, the board appointed a Task Force on AIDS, which met in August and produced a draft position paper on AIDS, as well as a member of recommendations for AAOMS programs and activities. The board reviewed the position paper and recommendations and approved their transmittal to the 1991 House of Delegates which adopted the position as outlined below.

It should be stressed that the position paper reflects the best advice to the membership available based on the current status of a variety of factors which have undergone rapid change and continue to do so. It is anticipated that both CDC and OSHA will be further refining the federal regulations that are presently in draft form. It is expected that the position paper will evolve over time as scientific evidence and professional considerations dictate.

The Association and its membership have responded to the growing epidemic by stressing the importance of education. Scientific programs have included presentations on the treatment of infectious diseases, as well as infection control techniques for the hospital and oral and maxillofacial surgery office.

It is the position of the AAOMS that an oral and maxillofacial surgeon (OMS) who is HIV seropositive must refrain from the clinical practice of oral and maxillofacial surgery, except as

permitted under applicable CDC guidelines.

The AAOMS will pursue, by all necessary means, measures to ensure the availability of disability insurance benefits and retirement benefits for those OMSs who discontinue the practice of oral and maxillofacial surgery as a result of HIV seropositive status.

A necessary adjunct to any policy statement or guidelines that the Association may adopt regarding AIDS and infection control is the timely and accurate dissemination of that information to the membership of the Association.

There will be regular communications with the membership through a special insert in the Digest. This will facilitate distribution of the House's actions and other government or public interest activities that are pertinent to members for use in their practices.

In addition, the board approved funding for development and publication of a patient information pamphlet on infection control in the OMS office. This will be made available for purchase by members as soon as possible and is intended to help answer patient inquiries on the subject.

It is recommended that OMS obtain the publication available from the ADA on infection control and compliance with federal requirements on hazardous material and waste disposal as a useful basis for sound practice. Information to this end is scheduled for dissemination to the Association's membership in the near future.

September 1991

Introduction

The American Association of Oral and Maxillofacial Surgeons (AAOMS) has developed this Position Paper to address issues of concern to the public and the dental specialty of oral and maxillofacial surgery. The AAOMS recognizes the myriad of issues related to Acquired Immune Deficiency Syndrome (AIDS) that involve public health, professional practice, ethics,

and legal aspects. This paper supersedes the 1988 AAOMS Board of Trustees Statement of AIDS.

The AAOMS acknowledges the scientific work of the Centers for Disease Control (CDC) and the National Institutes of Health (NIH) in investigating and reporting on AIDS. Scientific principles must be the basis for addressing the public health issues raised by the AIDS epidemic. Education of all Americans on the known aspects of AIDS is essential to establishing rational policy. Lack of understanding, which can produce unwarranted fear, must not be allowed to dominate consideration of public policy. Refusal by health care workers to treat AIDS patients or even suspected AIDS patients is as unwarranted as proposals for mandatory universal testing or criminal penalties for health care workers who are seropositive for the human immunodeficiency virus (HIV) and who treat patients.

The paramount concern of the AAOMS is to provide the highest quality of patient care in a safe manner. The protection of patients against the transmission of any infectious disease, such as hepatitis or the human immunodeficiency virus (HIV), has been a standard practice in the sterile barrier techniques developed by oral and maxillofacial surgeons and taught in dental schools. However, the need for precautions to prevent the transmission of an infectious disease is as important to surgeons and surgical staff as it is to patients. The data indicate that one health care worker transmitted the HIV to as many as five patients. This is the only reported transmission by a health care worker to patients. However, the CCD has identified at least 40 health care workers who have been infected with the HIV by treating patients. Clearly, surgeons and surgical staff, who perform exposure-prone invasive procedures must be able to take all necessary precautions. The CDC has stated that the characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.

AIDS is an infectious disease, and should be treated as a public health issue.

AIDS is a public health issue of concern to patients and health care professionals, as well as the general public. The treatment of patients with AIDS by health care professionals has been complicated by fear and political reaction. To address the treatment of AIDS patients, it must first be understood that AIDS is a disease. The treatment of AIDS as an infectious disease should not be affected by any separate political determination regarding AIDS as a disability. The AAOMS supports the principle of guaranteeing equal access to care for all patients, including those with AIDS or any infectious disease. Restrictions on the ability to communicate vital information, such as a patient's HIV status, when referring to another practitioner, can negatively affect quality of care.

The AAOMS opposes discrimination by an oral and maxillofacial surgeon or office staff in treating patients.

Since 1988, the Association has taken the specific position that refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical. This obligation is placed on the practicing OMS as a condition of membership in the AAOMS. In turn, the OMS must clearly identify this responsibility to the office staff. Education on universal precautions and barrier techniques is the most effective means to dispel unwarranted fears among health care professionals and the public.

HIV Testing of Health Care Practitioners: The AAOMS does not support mandatory testing of health care workers; however, OMSs and surgical assistants should be aware of CDC guidelines and use scientific and clinical data to determine the appropriateness of testing for their HIV status.

The AAOMS does not support mandatory testing of health care workers or patients. The most effective means to prevent the transmission of the HIV in the health care setting is to scrupulously follow universal precautions and to educate health care workers and patients on proper barrier techniques. Because an individual can be unknowingly infected, even with testing, all invasive procedures should be performed with the

assumption that there is a risk of HIV transmission.

The AAOMS endorses the CDC guidelines, which provide that health care workers who perform exposure-prone invasive procedures have an ethical and moral obligation to know their HIV status. The AAOMS encourages CDC and NIH to investigate what constitutes an "exposure-prone invasive procedure," and to make any such data known to health care agencies and professional organizations. OMSs should use up to date scientific and clinical data to fulfill their obligation to the public regarding the HIV status of health care workers.

However, neither the public nor health care workers should rely on testing as an assurance of safety against HIV transmission. The current blood test detects the presence of antibodies produced by the human immune system to fight the virus, not the virus itself. The validity of the blood test is diminished by the lapse of time that can occur between a person being infected with the HIV and the production of antibodies that would be detected by the test. This time lapse could be as long as six months. Also, the test can produce false negative results.

Moreover, the test only shows status for the moment of the test. A surgeon can have a negative test result, and then be infected by the next patient treated. The negative test result is thus meaningless to future patients. This raises the issue of how frequently testing would have to be conducted to be effective. Because of the flaws inherent in testing, there is no frequency of tests that would increase the effectiveness of testing. Neither patients nor health care workers should rely on a false sense of security produced by testing as protection against the transmission of the HIV. Constant testing is impractical, and expensive, and would need to be accompanied by the availability of counseling.

HIV Testing of Patients: The AAOMS does not support mandatory HIV testing of patients, but supports the right of a doctor to know the status of a patient for medical considerations.

The AAOMS does not support mandatory HIV testing of patients, for the same reasons discussed above regarding health

care workers. However, a health care worker needs to know the medical status of a patient to determine the appropriateness of treatment. The right of a doctor to know the status of a patient should not be infringed by anything but medical considerations.

It is difficult to discuss infection control for diseases such as hepatitis B and AIDS when AIDS is complicated by designation as a disability, raising issues of discrimination in treatment. Effective professional health care requires a consistent application of public policy. There is no medical reason to single AIDS out from other infectious diseases. This principle should be respected by health care workers as well as public policy makers.

Because the early manifestations of AIDS are often in the oral region, OMSs may often be in a position to diagnose the disease. The determination of appropriate care, such as whether surgery for another condition is indicated or which antibiotic should be prescribed, requires that the OMS be able to establish the patient's medical status, including HIV status, by testing if necessary. Early diagnosis of any disease, including AIDS, is in the best interest of the patient. Treatment can begin immediately, which can positively affect health status, and the risk of transmission can be reduced.

GUIDE TO PUBLIC HEALTH PRACTICE: HIV AND THE DENTAL COMMUNITY

Association of State and Territorial Health Officials

Association of State and Territorial Dental Directors

October 1989

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FOREWORD

The public health community has a unique responsibility in meeting the challenges presented by the human immunodeficiency virus (HIV). State and local health departments have worked to prevent the spread of HIV through testing, counseling, partner notification, and education programs, and they continue to work to meet the needs of those already infected with HIV. The dental community's responsibility regarding HIV lies in preventing transmission of the virus in the dental setting, through utilization of appropriate

infection control measures, and in treating those infected with HIV.

This report presents official policies and recommendations on HIV and the role of the dental community that were formulated by the Association of State and Territorial Health Officials (ASTHO) and the Association of State and Territorial Dental Directors (ASTDD).

Appendix A contains a model questionnaire for use by state health departments and their dental programs in assessing the HIV-related knowledge, attitudes, and practices of dental health care workers. It will be particularly helpful to state health departments in targeting HIV and infection control education efforts for dental health care workers.

Appendix B presents a discussion of current practices in disinfection and sterilization of dental equipment and devices with respect to transmission of HIV. This section also contains recommendations for reducing the risk of transmitting HIV and other bloodborne pathogens in the dental setting, as well as a summary of the current information on the cost of infection control.

We want to thank all those who participated in the *Forum on HIV Prevention and Infection Control for the Dental Health Community*. Their experience and insights contributed greatly to the development of this report. Special thanks go to members of the Work Group for lending their time and expertise to this project. Unique contributions were also made by Dr. Nelson Moyer, Dr. Jeffrey Rosenbaum, and Dr. Barbara Gerbert.

Comments from readers would be appreciated as an indication of the need for expanding or revising the recommendations. Please address comments to the Public Health Foundation, 1220 L Street, N.W., Washington, D.C. 20005.

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GUIDE TO PUBLIC HEALTH PRACTICE: HIV AND THE DENTAL COMMUNITY

I. INTRODUCTION

A. The Role of State Health Agencies in HIV Control

Since the identification of the human immunodeficiency virus (HIV), state health agencies (SHAs) have been directly involved in preventing the spread of HIV and in implementing treatment interventions. State health agencies' HIV risk reduction programs include comprehensive disease surveillance activities and widespread testing, counseling, treatment, and education services. SHAs have focused on reducing public misunderstanding about HIV and on securing a broad, articulated community consensus on public health programs for combating HIV. [Footnote 1] Scott, H. Denman, M.D., M.P.H., "AIDS Control From a State Health Department Perspective." Testimony before the Presidential Commission on the Human Immunodeficiency Virus Epidemic. March 1, 1988, Washington, D.C. [end Footnote 1]

Most SHAs have developed plans to slow the spread of HIV and to care for those infected with the virus. The scope of the plans varies widely and most do not include comprehensive strategies for use by state dental health programs in dealing with the epidemic. It is clear, however, that dental health care workers (DHCWs) have an important role to play in reaching the goals of state HIV Centers for Disease Control (CDC), dental health care workers are persons whose activities involve contact with patients or with blood or other body fluids from patients in a dental health care setting. [Footnote 2] "Recommendations for Prevention of HIV Transmission in Health-Care Settings," *Morbidity and Mortality Weekly Report.* Centers for Disease Control, August 21, 1987, Vol. 36, No. 2S, p. 3S. [end Footnote 2]

B. The Dental Community and HIV Control

Dental health care workers play a major role in the early diagnosis, treatment, and referral of HIV- infected individuals for additional health care and counseling, as well as in the provision of routine dental care and infection control. [Footnote 3] Statement of Vincent C. Rogers, D.D.S., M.P.H., for the American Dental Association to the Presidential Commission on the Human Immunodeficiency Virus Epidemic. January 14, 1988, Washington, D.C. [end Footnote 3]

A study of people with or at risk for HIV infection found that one-third of the study group exhibited oral manifestations of HIV infection. [Footnote 4] Silverman, Sol, Jr., M.A., D.D.S., et al., "Oral Findings in People With or at Risk for AIDS: A Study of 375 Homosexual Males," *Journal of the American Dental Association.* February 1986, Vol. 112, p. 189. [end Footnote 4] The oral manifestations of HIV infection include, among others, Kaposi's sarcoma, severe oral herpes simplex, gingivitis, oral candidiasis, oral warts, oral hairy leukoplakia, HIV periodontitis, and atypical mycobacterial infections. In addition, dentists also may detect cervical lymphadenopathy and other head and neck manifestations which occur in approximately 95 percent of patients with HIV infection. [Footnote 5] Richards, J.M., "Notes on AIDS," *The British Dental Journal.* March 23, 1985, p. 200. [end Footnote5]

HIV often results in multiple and overwhelming opportunistic infections. The virus is spread by sexual contact or sharing needles with infected individuals, and, less commonly, through transfused blood and blood products. The virus also may be transmitted from infected mother to infant during pregnancy or birth, or shortly after birth, most likely through breast milk. [Footnote 6] *Facts About AIDS.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control. Spring 1987, p.1. [end Footnote 6]

Dental health professionals who do not take proper precautions may be at risk for contracting saliva and bloodborne viral diseases, including hepatitis B (HBV) and HIV. [Footnote 7] "Infection Control in the Dental Office: A Realistic Approach." Interview with Charles H. Boozer, D.D.S., *Journal of the American Dental Association.* April 1986, Vol. 112, p. 463. [end Footnote 7] CDC estimates that there are nearly 1 million carriers of HBV in the United States and that up to 1.5 million Americans may carry HIV. In many cases, infected individuals are asymptomatic; therefore, dental health care workers, as well as the patients themselves, may be unaware of the patients' HBV and HIV seropositive status. Although HBV carries with it a higher risk of transmission than does HIV, it has not created the fear and stigma that have been associated with HIV.

A number of studies suggest that many DHCWs lack basic knowledge about treating HIV-infected patients. A study conducted at the University of California at San Francisco School of Dentistry found that only 57 percent of dental health professionals believed they had the skills needed to treat HIV patients safely and 75 percent preferred to refer persons at risk for HIV to other practitioners. [Footnote 8] Gerbert, Barbara, Ph.D., "AIDS and Infection Control in Dental Practice: Dentists' Attitudes, Knowledge, and Behavior," *Journal of the American Dental Association.* March 1987, Vol. 114, p. 312. [end Footnote 8]

A study released by the American Dental Association (ADA) found that only 31 percent of dentists were willing to treat HIV-infected patients, although 73 percent were willing to treat patients with HBV, which has a higher risk of transmission in the dental setting. In addition, only 5 percent of the dentists

believed that a private dental office was the best place to treat an HIV-infected patient. [Footnote 9] Verussio, A. Carl, Ph.D., et al, "The Dentist and Infectious Diseases: A National Survey of Attitudes and Behaviors," *Journal of the American Dental Association.* May 1989, Vol. 118, p. 560. [end Footnote 9]

Despite these findings, there is also good news. Researchers at the University of California at San Francisco reported that education programs are effective in improving dentists' attitudes about treating HIV-infected patients. A demonstration education program they conducted resulted in the participating dentists becoming more knowledgeable about HIV. They were also more willing to treat persons with HIV and to carry out a complete examination inside the mouth and external head and neck area. [Footnote 10] Gerbert, Barbara, Ph.D., et al, "Changing Dentists' Knowledge, Attitudes, and Behaviors Relating to AIDS: A Controlled Educational Intervention," *Journal of the American Dental Association.* June 1988, Vol. 116, No. 7, p. 851. [end Footnote 10]

A number of organizations, including CDC and ADA, have issued guidelines, using HBV as the model, for preventing the transmission of infectious diseases in dental settings. Although there are still many dental professionals who do not follow these guidelines, recent surveys suggest progress is being made. For example, in following a 1986 survey, the ADA found that the number of dentists who reported wearing gloves with every patient more than tripled in two years, rising from 23 percent of the survey respondents in 1986 to 76 percent of those responding in 1988. [Footnote 11] Verussio, A. Carl, Ph.D., et al, "The Dentist and Infectious Diseases," p. 555. [end Footnote 11] More improvements can be anticipated as DHCWs comply with the federal Occupational Safety and Health Administration (OSHA) requirements for worker protection against infectious agents.

C. The Role of State Health Agency Dental Programs in HIV Control

State dental health programs are charged with the responsibility of ensuring, promoting, and protecting the oral health of the public through organized community-based

activities. To this end, they are responsible for assessing the oral health needs of the public, and for developing and implementing plans for the prevention and control of dental diseases.

With respect to HIV, it is important that the directors of state health agencies clearly establish the role DHCWs have in controlling the spread of the HIV epidemic through early detection of oral manifestations of HIV, practicing appropriate infection control procedures, and patient counseling. Direct collaboration between state dental health programs and state HIV programs on all matters relating to the role of DHCWs in controlling the spread of HIV is important in limiting the HIV epidemic.

II. PROGRAM PLANNING

After a two-year study on the status of public health programs in the United States, the Institute of Medicine released a report containing recommendations for improving the U.S. public health system. Among the recommendations was a charge to SHAs to: assess the health needs within the state; establish statewide health objectives; and assure appropriate statewide efforts to develop and maintain personal and educational health services, provide access to necessary services, and solve problems inimical to the public's health. [Footnote 12] *The Future of Public Health,* Institute of Medicine. National Academy Press, Washington, D.C., 1988, p. 143. [end Footnote 12] ASTHO and ASTDD believe that similar recommendations for state dental health programs will serve to improve public understanding and access to dental health services in light of the growing challenge presented by the HIV epidemic.

ASTHO and ASTDD recommend the following:

> State dental health programs should develop and implement plans for monitoring the needs of HIV-infected individuals in the dental setting, as well as the needs of DHCWs with respect to HIV. The plans should assess the ability of current programs and resources to meet those needs in order to facilitate development of specific goals and objectives.

Program evaluation should result in development of appropriately targeted patient care services, educational programs for the public and health professionals, safety and infection control programs, and policies such as those related to confidentiality of medical information. The Centers for Disease Control should provide guidance to SHAs in the development of such programs.

Future program evaluations should address the achievement of previously defined goals and objectives and the establishment of new goals.

State dental health programs should identify training and educational needs of DHCWs through the use of knowledge, attitude, and practices (KAP) surveys. This information should be used to target education efforts. The HIV-related KAPs of DHCWs should be monitored over time to evaluate the effectiveness of education efforts.

III. EDUCATION

Education is the first line of defense in the fight against HIV infection. Widespread public and professional education about HIV is the most effective way to prevent transmission of the virus, to stop HIV-related discrimination, and to assure access to health care. A recent study indicates that educational interventions that acknowledge dentists' fears and concerns, while addressing their knowledge and behavioral gaps, can be effective in enhancing the response of dentists to the HIV epidemic. [Footnote 13] Gerbert, Barbara, Ph.D., et al., "Controlled Educational Intervention," pp. 851-854. [end Footnote 13]

ASTHO and ASTDD recommend the following:

State dental health programs should assist in ensuring that all DHCWs are knowledgeable about HIV infection and related subjects so they can provide competent care and accurate information to patients and can prevent

unnecessary risk to themselves, their staff, and their patients.

Appropriately trained DHCWs should:

Understand the epidemiology of HIV and other infectious agents;

Be able to identify oral manifestations of HIV;

Recognize appropriate situations in which to refer patients to other health care providers;

Develop and implement appropriate patient management plans;

Know how to access HIV-related information and services;

Be familiar with confidentiality and discrimination laws in their jurisdiction;

Adhere to current federal, state, and local regulations and guidelines on infection control;

Be aware of their responsibility to treat individuals with HIV;

Implement proper management of medical waste; and

Be able to educate their patients about HIV risk factors and modes of transmission.

State dental health programs should work in collaboration with CDC and other federal agencies, local health departments, state AIDS coordinators, professional associations, AIDS Education and Training Centers (ETCs), state dental licensing boards, dental and allied dental schools, and private providers, to develop and provide continuing education on HIV-related issues to DHCWs.

State dental health programs should coordinate efforts with state dental licensing boards to ensure that dental professionals avail themselves of continuing education related to infection control and bloodborne diseases, including HIV. This should be done by requiring continuing education credits in these areas as a condition for maintaining licensure. These licensure requirements should be consistent with state requirements.

State dental health programs should work with Schools for DHCWs to integrate appropriate material about HIV into their curricula to ensure that all students are educated about infection. Dental schools should provide and encourage HIV-related research and their experiences.

SHAs should include in their public education programs accurate information to diminish irrational fears about transmission of HIV through dental treatment.

SHAs should work with the private dental community to encourage all dental offices to offer literature about HIV and infection control procedures used in their offices. In explaining the use of infection control procedures, DHCWs can both educate their patients and reassure them that their visit does not place them at risk of infection.

IV. ORAL HEALTH CARE MANAGEMENT OF HIV-INFECTED PATIENTS

Many DHCWs have responded quickly to the need to provide high quality dental care to HIV infected persons. However, many barriers to appropriate treatment still exist. Recent surveys of dentists have identified some of the major attitudinal barriers to caring for people with HIV infection. These include the dentists' fear of contracting HIV from patients and fear of losing other patients. Dentists also anticipate problems with their staff and some believe they lack skills necessary to treat HIV-infected individuals. Some dentists feel that by excluding patients with known HIV infection they will keep their practice free from HIV. This misconception has led some dentists to discontinue treatment of patients with HIV infection. [Footnote 14] Raper, P.E., "AIDS: Prevent Its Spread, Treat Its Victims," *Dentistry Today*. 1985, Vol. 4, No. 8, pp. 1, 21. [end Footnote] However, because asymptomatic patients who are infected with HIV may not disclose or may be unaware of their HIV status, it is not possible to selectively exclude HIV-infected patients from dental practices.

A. Access to Care/Duty to Treat

Improving access to health care is one of the greatest challenges facing the nation's health care system today. While access to appropriate health care remains a problem for many Americans, HIV-infected persons face sometimes insurmountable barriers in securing and maintaining health insurance coverage and in finding health care providers willing to treat them.

All DHCWs have an ethical, professional, and, in most cases, legal obligation not to engage in discrimination in their decisions to treat patients. Although a dentist has the right not to accept a new patient for treatment when no immediate emergency exists, a dentist may not refuse to accept a new patient because of that person's race, gender, ethnicity, or, in some state/localities, sexual orientation and/or disability. [Footnote 15] Logan, Mary, J.D., "Legal Implications of Infectious Disease in the Dental Office," *Journal of the American Dental Association*. December 1987, Vol. 115, p. 853. [end Footnote 15]

The federal government, as well as many states and municipalities, have ruled that HIV-related conditions (including the presence of HIV antibodies) are handicaps protected by existing handicapped discrimination laws. [Footnote 16] Ibid. [end Footnote 16] Recipients of federal funds, which arguably may include dentists who accept Medicaid and Medicare, are also subject to these statutes. [Footnote 17] Ibid. [end Footnote 17]

ASTHO and ASTDD recommend the following:

> DHCWs have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV infection, in the same manner as they would to other patients.

In some instances, referral to dental specialists for HIV-related problems may be required, but such referrals should be limited to specialized procedures normally referred to other health care providers. (See Section IV.C.) HIV seropositivity is not sufficient cause for referral.

B. Diagnosis and Treatment of HIV-Associated Conditions by DHCWs

Because oral lesions may be an early indication of HIV infection and such oral manifestations occur in approximately one-third of those infected with HIV, a DHCW, in many cases, may be the first health care provider to observe evidence of HIV infection in a patient. Therefore, DHCWs must be able to recognize the oral manifestations of HIV infection.

ASTHO and ASTDD recommend the following:

Every dental patient should have a complete oral health history taken and be given thorough oral examination, including the head and neck.

Consistent with usual practices, each patient's health history should be updated regularly and appropriate notes made in the patient's chart.

If a DHCW finds evidence of oral manifestations of HIV infection, the DHCW should update the patient's history to include detailed information on general health status, any observed oral signs and symptoms, and a recommendation that a primary health care provider evaluate the patient's immune status.

The DHCW should be aware of the confidentiality of information regarding HIV status. Entries made in the written health history should be consistent with current legal and ethical standards.

Counseling, testing, and diagnosis of HIV-infected individuals are the responsibility of the primary health care provider or SHA counseling and testing services. If a

patient with suspected HIV infection does not have a primary health care provider, the DHCW should assist the patient in locating necessary services.

All DHCWs should give patients, including HIV-infected patients, the opportunity to express treatment preferences as early as possible after diagnosis. Such opportunities help to maintain an individual's sense of self-worth and personal dignity.

DHCWs involved in direct patient care have a need to know relevant HIV-related patients information which might assist them in the treatment and care of patients.

C. Referral To and From Other Health Care Providers

ASTHO and ASTDD recommend the following:

Treatment and management of oral manifestations of HIV infection should take place in close collaboration with the patient's primary health care provider. The primary health care provider should be encouraged to consult with a dentist who is participating in the patient's overall health care management.

The diagnosis or suspicion of HIV infection is not sufficient cause for referral to another health care provider. Consistent with usual practices, referrals of HIV-infected patients to another dentist, facility, or primary care provider should be made when the primary dentist has the need of another's skills, knowledge, equipment, or experience. A referral should also be made if the dentist determines, after consultation with the patient's primary health care provider, that the patient's health would be significantly compromised by the provision of dental treatment. [Footnote 18] *ADA Principles of Ethics and Code of Professional Conduct,* American Dental Association. July 1988, p.2. [end Footnote 18]

When referrals are necessary, dentists should communicate clearly with their patients about the referral to avoid frustrating and confusing the patients or undermining their

confidence in the care provided. DHCWs should encourage patients' questions and provide answers about the referral as a way to alleviate some of the fears associated with unfamiliar treatments or providers. [Footnote 19] Ibid., p. 600. [end Footnote 19]

DHCWs should know how to gain access to other services for HIV-infected patients. These services may include medical, legal, and psycho-social components. SHAs and their dental programs should work with private dental associations and local health departments to make this information readily available.

D. Overcoming Financial Barriers to Treatment

Individuals with HIV infection often face financial barriers to health services, including dental treatment. In many cases, a person with HIV-related illness loses income and insurance coverage due to his or her inability to work. In addition, it is very difficult for HIV-infected persons who are uninsured to obtain health insurance coverage due to restrictions regarding pre-existing conditions.

To date, most known cases of HIV infection have occurred in single males, yet this group receives the lowest priority in determination of medical indigence in state Medicaid program eligibility guidelines. [Footnote 20] Statement of Vincent C. Rogers, D.D.S., M.P.H., for the American Dental Association to the Presidential Commission on the Human Immunodeficiency Virus Epidemic. January 14, 1988, Washington, D.C. [end Footnote 20] Many people with HIV infection eventually become Medicaid eligible; however, insufficient provider reimbursement levels, as well as excessive paperwork, delayed reimbursement, and other inconveniences, make it increasingly difficult to locate dentists willing to treat Medicaid patients. Some states do not cover adult dental benefits, and others limit adult dental benefits to emergency care only. Currently, Medicare benefits do not include coverage for routine dental health care services.

ASTHO and ASTDD recommend the following:

State and local governments should work with the federal government to identify methods for improving access to dental care for HIV-infected individuals within the Medicaid program. These methods may include expanding eligibility criteria, expediting coverage, improving reimbursement rates, and expanding covered dental services, perhaps through utilization of Medicaid waivers.

Care for HIV-related oral problems should be covered under dental, medical, and health insurance plans.

V. SAFETY AND INFECTION CONTROL

A. Procedures for Infection in the Dental Setting

Implementing current standards of infection control is necessary to ensure the safety of both DHCWs and patients. DHCWs can reduce the risk of HIV transmission in dental settings by following the infection control procedures recommended by CDC and ADA for infectious bloodborne diseases.

Infection control measures, as recommended by CDC and ADA and as required by OSHA, are effective in reducing the risk of transmitting infectious agents, including HIV. All health facilities, including dental offices, are required to meet OSHA standards for worker protection from infectious agents. These standards include office infection control programs and worker training and education. OSHA requires DHCWs to use barrier techniques with all patients to reduce the risk of transmitting bloodborne infectious disease like HBV and HIV. In addition, all dental offices are subject to inspections by OSHA.

Part of an effective infection control program includes immunization of DHCWs with the HBV vaccine. The HBV vaccine is widely available and is highly effective against HBV. Its use by DHCWs has been strongly urged by CDC. [Footnote 21] "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B, and Other Bloodborne Pathogens in Health-Care Settings," *Morality Weekly Report.* Centers for Disease Control. June 24, 1988, Vol. 37, No. 24, p. 1. [end Footnote 21]

ASTHO and ASTDD recommend the following:

> State and local dental health programs and professional dental associations should collaborate to ensure that all DHCWs adhere to universal precautions and employ appropriate infection control procedures at all times. Because it is not feasible for DHCWs to confirm the HIV status as well as the status of other infectious bloodborne diseases for all patients, infection control procedures should be implemented as though each patient were potentially HBV- and HIV-infectious.
>
> Employers of DHCWs have an obligation to ensure that necessary infection control equipment and supplies are available and that all workers are adequately trained in their use, in accordance with existing federal and state regulations and guidelines. Documentation of infection control procedures used in the office and a record of the training for each staff member should be maintained, consistent with OSHA guidelines.
>
> State dental health programs and private dental organizations should work together to ensure that dental offices have policy statements in place regarding exposure of employees to blood and body fluids, in order to ensure appropriate medical care, follow-up, and monitoring. [Footnote 22] *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic.* June 1988, p. 34. [end Footnote 22]
>
> Dental employers should offer to provide the HBV vaccine for employees involved in direct patient care.
>
> Medical waste should be handled and disposed of in accordance with federal, state, and local laws and regulations.

B. The HIV-Infected Dental Health Care Worker

Experts on infection control have reported that there is minimal risk of harm to patients when an HIV- or HBV-infected DHCW performs invasive procedures, as long as the DHCW uses

recommended barrier techniques. [Footnote 23] Logan, Mary, J.D., "Legal Implications," p. 852. [end Footnote 23]

ASTHO and ASTDD concur with CDC recommendations regarding the management of HIV-infected health care workers:

> DHCWs with impaired immune systems should be counseled about the potential risk to themselves of treating patients who have transmissible infections and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents.
>
> The adequate and safe treatment of patients by an HIV-infected DHCW must be determined on an individual basis. These decisions should be made by the DHCW's primary care physician. [Footnote 24] "HIV Transmission Recommendations," *Morbidity and Morality Weekly Report,* p. 16S. [end Footnote 24]

ASTHO and ASTDD also recommend the following:

> HIV-infected DHCWs should be encouraged to practice for as long as they are able to perform their duties safely and competently.
>
> DHCWs should be aware of and follow current laws and regulations regarding the treatment of patients by health care workers with infectious diseases.

VI. CONFIDENTIALITY OF HEALTH INFORMATION

Ensuring confidentiality of HIV-related information is critical to maintaining and promoting public confidence in the health care delivery system. Protecting the confidentiality of public health and medical records is both a legal and ethical duty. Because reported or feared breaches of confidentiality may result in actual or perceived HIV-related discrimination, such breaches discourage individuals from learning their HIV status. Without adequate confidentiality protection, it is difficult to ensure that people are counseled on how to prevent HIV transmission and that they are provided appropriate health care services.

ASTHO and ASTDD define HIV confidentiality as "the protection from release of information, without the consent of the named party, which links the individual's identity to facts about HIV seropositivity, behavioral risk factors, or application for related services. Disclosure of information without documented consent of the individual is permitted only when the disclosure is necessary for the individual's medical care, or is required by law." [Footnote 25] *Guide to Public Health Practice: AIDS Confidentiality and Anti-Discrimination Principles,* Association of State and Territorial Health Officials, March 1988, p. 5. [end Footnote 25] This definition also applies to dental care.

In addition, testing without counseling, as well as testing as a means for excluding patients from treatment, is unethical. Testing must always be: (1) accompanied by the documented informed consent of the person being tested; (2) strictly confidential, except when disclosure is necessary for the individual's medical and dental care, or is allowed or require by law, (3) done in conjunction with adequate pre- and post-test counseling; and (4) done in accordance with state laws. [Footnote 26] Ibid., p. 6. [end Footnote 26]

ASTHO and ASTDD recommend the following:

> State dental health programs should collaborate with professional dental associations to develop model policies consistent with the confidentiality laws in their states to assure that medical/dental information is collected and managed to ensure confidentiality.
>
> SHAs should work through their dental programs, and in collaboration with professional dental associations and state dental associations and state dental licensing boards, to ensure that DHCWs are familiar with the confidentiality and medical records laws in their jurisdictions before transferring patient information to other health care providers. DHCWs should understand the potential consequences both to the patient and the DHCW of breaches of confidentiality.

> Dentists should obtain the patient's permission before forwarding health records that contain information concerning HIV status or consulting with another dentist or physician when circumstances do not permit patient anonymity. [Footnote 27] Ibid., p. 7. [end Footnote 27]
>
> The dentist is responsible for approving the release of HIV-related information to another dentist or physician that is necessary for treatment.
>
> An authorization for disclosure of HIV-related information must be documented except where disclosure is authorized by law. Although state laws vary, the authorization should, in general, specify to whom the information will be disclosed, how the information will be used, and the time period during which the consent will remain valid. Patients should be advised of their right to refuse authorization without threat of discrimination. Further, patients should be advised of the potential consequences, including discrimination, of voluntarily revealing their HIV antibody status to others when not necessary.
>
> Because an individual's dental record may include confidential information, including HIV status, all patient records should be accessible to only to persons authorized by the dentist as part of patient care. Policies to maintain confidentiality should be established and adhered to in all dental settings.

AADS REVISED POLICY STATEMENT III B, AS AMENDED BY THE AADS HOUSE OF DELEGATES, MARCH, 1993, CHICAGO, ILLINOIS

Infectious Diseases. Dental education has the obligation to maintain standards of health care and professionalism that are consistent with the public's expectations of the health professions.

1. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.

2. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or hepatitis B infection. These patients must not be subjected to discrimination.

3. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.

4. The dental education institution is ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious disease must consult with appropriate health-care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer of the dental education institution should take steps consistent with the advice of appropriate health-care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others. In addition, the chief administrative officer of the institution must facilitate appropriate counseling and follow-up care, and should consider establishing retraining

and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Dental education institutions should make institutional guidelines and policies in this area available to current and prospective students, staff, and faculty.

5. Chief administrative officers of dental education institutions must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous-waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines and must be provided to all faculty, students, and appropriate support staff. To protect faculty, students, staff, and patients from possibility of cross-contamination and infection, asepsis protocols must include policy requiring the availability and use of gloves, masks, and protective eye wear by faculty, staff, and students in both preclinical and clinical situations.

6. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should (1) demonstrate proof of immunity, (2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or (3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions should require pre-matriculation and annual testing for tuberculosis.

***

…. dental personnel to meet dentistry's responsibilities to the public.

D. Research, clinical trials, and demonstration projects that are supported in part or in whole by commercial and other extramural sources.

1. The AADS encourages dental education institutions and dental educators to interact with commercial and other extramural sponsors of research, clinical trials, and demonstration projects under conditions in which the academic rights of faculty are protected. These conditions include rights of publication, ownership of intellectual property, and rights of patent and copyright within institutional policy, subject to appropriate contractual protection of the sponsor's legitimate interests.

2. The AADS encourages publication by faculty of the results of research, clinical trials, and demonstration projects supported by commercial and other extramural sponsors.

a. Peer review by scientists/educators with expertise in the relevant field(s) of the research or project is the best means of assuring quality of the publication.

b. The AADS discourages submission of manuscripts to any publisher that allows sponsors of the work to influence editorial policy or judgment after the completion of the peer review process.

III. Delivery of Care
A. Objectives

1. The public need and demand should be the criteria for the number and kind of practitioners educated. The actual needs and demands of the public as well as the number and kind of practitioners who can accommodate those needs and demands should be revevaluated. Analysis of those needs and demands should be constantly monitored so that dental education institutions do not overproduce or underproduce members of the dental team in a given area. Dental education institutions should provide extramural experiences for their

students in various community settings.

2. The responsibilities of the dental team should be redefined. In the process, care should be taken to ensure career satisfaction of those to be affected.

3. Dental education institutions should emphasize the importance of the dentist's social responsibility as well as new modes of practice which will assure improved quantity and quality of dental care.

4. Dental schools are encouraged to use stated criteria and demonstrated competencies as the primary basis for, and judgment of, student performance.

5. Chief administrative officers of dental education institutions should consider appointing a collegiate safety officer who is responsible for all radiation sources within the dental school. If a university radiation officer exists, the collegiate radiation officer should be subject to general university regulations.

6. Patients seeking treatment in an educational institution should be made aware of the scope of services available at that institution, should have the opportunity to agree to a treatment plan, should be provided with an estimate of the cost of treatment, and should be informed of any limitations to therapy. Patients accepted for treatment should receive the indicated therapy according to a properly sequenced treatment plan. The time between the screening assessment and the assignment for appropriate care should be kept to a minimum.

III. Delivery of Care
B. Infectious Diseases.

Dental education has the obligation to maintain standards of health care and professionalism that are consistent with the public's expectations of the health professions.

1. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.

2. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or hepatitis B infection. These patients must not be subjected to discrimination.

3. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.

4. The dental education institution is ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious agent must consult with appropriate health-care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer of the dental education institution should take steps consistent with the advice of appropriate health-care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others. In addition, the chief administrative officer of the institution must facilitate appropriate counseling and follow-up care, and should consider establishing retraining and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Dental education institutions should make institutional guidelines and policies in this area available to current and prospective students, staff, and faculty.

5. Chief administrative officers of dental education institutions must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous-waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines, and must be provided to all faculty,

students, and appropriate support staff. To protect faculty, students, staff, and patients from the possibility of cross-contamination and infection, asepsis protocols must include policy requiring the availability and use of gloves, masks, and protective eye wear by faculty, staff, and students in both preclinical and clinical situations.

6. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should (1) demonstrate proof of immunity, (2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or (3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions should require pre-matriculation and annual testing for tuberculosis.

III. Delivery of Care
C. Dental Health Personnel

1. The American Association of Dental Schools makes the following statements concerning the current dental health personnel situation.

Dental schools are important national, regional, state, and community resources.

Dental schools are providers of scientific research, predoctoral and postdoctoral and allied dental education, as well as continuing education for the practicing profession, and are

providers of comprehensive dental care for those otherwise underserved.

Dental schools are a vital component of the health sciences segment of universities.

Major reductions have been made in dental school enrollment levels nationally in response to the changing size of the personnel and applicant pools and demand for care.

Continued and haphazard reduction of dental school enrollment levels may result in a personnel supply that is inadequate to meeting the dental care demands of the changing population in the United States within the next two decades. Such an unfortunate situation would result in a costly effort to restore this valuable resource to adequate size. Further, it would compromise the ability to positively address and overcome the current inadequate representation of minorities and women in the practicing profession.

Therefore, the AADS believes that further reductions in first-year dental school enrollments are not in the public interest. The Association commits itself to monitor the changing environment in which dental schools operate and dentists practice, and to review and adjust its policy regarding dental school enrollment as indicated.

III. Delivery of Care
D. Licensure and Certification

1. The American Association of Dental Schools should cooperate with the American Dental Association, the American Dental Hygienists' Association, and the American Association of Dental Examiners to develop uniform standards for licensure and credentialing that would permit freedom in geographic mobility for dentists and dental hygienists.

2. The Association should explore the medical-legal and infection-control liabilities and the ethical issues associated with the delivery of care in clinical entry-level board examinations.

3. The Association, in cooperation with appropriate

organizations and agencies, should identify the minimum competencies needed by dental personnel to participate effectively in the delivery of health care.

4. The Association, both through cooperative venture and on its own initiatives, should support the development of valid and reliable methods that can be used nationally to measure minimum competencies of dental personnel.

5. The Association, in cooperation with appropriate organizations and agencies, should explore the development of alternative testing methods, and support the development of appropriate demonstration projects and pilot programs.

6. The American Association of Dental Schools, in cooperation with appropriate agencies, should work diligently toward eliminating the use of human subjects in entry-level examinations.

7. As a long-term goal, the Association recommends elimination of state and regional entry-level clinical licensure examinations for dentists and dental hygienists who are graduates of programs accredited by the Commission on Dental accreditation, and have successfully completed the National Board Dental Examinations or the National Board Dental Hygiene Examinations.

DEFENDANT RANDON BRAGDON, D.M.D.'S RESPONSE TO PLAINTIFF'S REQUEST FOR ADMISSIONS

(dated 04/13/95)

(Caption omitted in printing)

1. From at least since 1980 continuously through the date of answering these requests for admission, Bragdon has been the sole owner of a dental practice with an office located at 30 Judson Boulevard in Bangor, Maine.

RESPONSE: Admitted.

2. From at least 1980 continuously through the date of answering these requests for admission, Bragdon has established and controlled all of the operations, policies and procedures of the Bragdon Dental Practice.

RESPONSE: Admitted.

3. On September 16, 1994, Bragdon was the owner and operator of the professional office of a health care provider located at 30 Judson Boulevard in Bangor, Maine.

RESPONSE: Admitted.

4. During the calendar year 1994, the Bragdon Dental Practice did not have any limitations or restrictions on the patients it would accept based upon gender, age or geographical location of the patient.

RESPONSE: Admitted.

5. During the calendar year 1994, the Bragdon Dental Practice did not limit or restrict its services only to patients who were referred to the Bragdon Dental Practice by another dentist or health care provider.

RESPONSE: Admitted.

6. During the period 1990 through the date of answering

these requests for admission, the Bragdon Dental Practice had accepted as new patients individuals who called the Bragdon Dental Practice for an appointment after learning about the Practice from another patient of Bragdon or the Bragdon Dental Practice.

RESPONSE: Admitted.

7. During the period 1990 through the date of answering these requests for admission, the Bragdon Dental Practice had accepted as new patients individuals who did not know existing patients of Bragdon.

RESPONSE: Admitted.

8. On September 16, 1994, Bragdon was accepting new patients.

RESPONSE: Admitted.

9. From 1980 to the date of answering these requests for admission, the Bragdon Dental Practice has been listed in the Bangor area Yellow Pages.

RESPONSE: Admitted.

10. The document attached as Exhibit A to these requests for admission is a genuine, true and accurate copy of the "Infectious Disease Policy" of the Bragdon Dental Practice which was written by Bragdon.

RESPONSE: Admitted.

11. At all times during which the Infectious Disease Policy has been in effect, including September 16, 1994, and the date of answering these requests for admission, there have been no circumstances under which Bragdon would provide dental treatment in the Bragdon Office to a patient with HIV or AIDS.

RESPONSE: Admitted.

12. Bragdon does not intend to eliminate or revoke the

Infectious Disease Policy with respect to patients with HIV or AIDS.

RESPONSE: Admitted.

13. In the future, Bragdon does not plan to provide dental treatment in the Bragdon Office to patients with HIV or AIDS.

RESPONSE: Denied. Dr. Bragdon does not know what will happen in the future.

14. On September 16, 1994, filling a cavity was a dental procedure which was within Bragdon's realm of competence and the scope of services of the Bragdon Dental Practice.

RESPONSE: Defendant admits that filling a cavity was within his realm of competence and the scope of services of the Bragdon Dental Practice for patients free from infectious diseases. Defendant denies that filling a cavity at his Bangor office was within his realm of competence and the scope of services of the Bragdon Dental Practice for patients who were not free from infectious diseases.

15. The procedure for filling a cavity of an HIV-positive person does not require specialized training which is different than the procedure for filling the cavity of a patient who is not HIV-positive.

RESPONSE: Denied.

16. If Bragdon provides dental services to a patient with HIV or AIDS in a hospital surgical operatory rather than at the Bragdon Office, the patient, not Bragdon, must pay additional cost of the hospital surgical operatory.

RESPONSE: Admitted.

17. As of September, 1994, Bragdon understood the substance of and followed in the Bragdon Office all of the recommendations and requirements of the CDC, OSHA, and the American Dental Association to prevent the transmission of blood-borne pathogens, including HIV, in practice of dentistry.

RESPONSE: Denied. Dr. Bragdon admits that the assertions are true to the best of his knowledge.

18. As of September 16, 1994, Bragdon had not obtained privileges or credentials at any hospital or other institution to use a surgical operatory for the purpose of performing dental procedures or treatment on his private patients.

RESPONSE: Denied.

19. As of September 16, 1994, Bragdon had not applied to any hospital or other institution to use a surgical operatory for the purpose of performing dental procedures or treatment on his private patients.

RESPONSE: Denied.

20. On September 16, 1994, Sidney Abbott was present at the Bragdon Office for a previously scheduled appointment.

RESPONSE: Admitted.

21. On September 16, 1994, Bragdon learned that Ms. Abbott was HIV-positive which she disclosed in response to Bragdon's inquiry whether Ms. Abbott had any medical conditions.

RESPONSE: Denied.

22. On September 16, 1994, Bragdon determined that Ms. Abbott had a cavity which required a filling.

RESPONSE: Admitted.

23. On September 16, 1994, Bragdon told Ms. Abbott that he would not fill her cavity in the Bragdon office, but would fill Ms. Abbott's cavity in a hospital surgical operatory.

RESPONSE: Admitted.

24. On September 16, 1994, Bragdon told Ms. Abbott that

she would be responsible for the cost of the hospital surgical operatory referred to in request for admission number 23.

RESPONSE: Admitted.

25. Bragdon believes that the people who are HIV-positive in the United States are most likely to be gay men, people who use or have used intravenous drugs, and their sexual partners.

RESPONSE: Denied.

26. On September 16, 1994, Bragdon used a heat sterilization process to sterilize all nondisposable dental instruments which he ever places in a patient's mouth, including the high and low speed dental handpieces.

RESPONSE: Denied.

27. The process of heat sterilization kills all microbial life, including HIV.

RESPONSE: Denied.

28. CDC has not documented any case of transmission of HIV from a patient to a dental health care.

RESPONSE: Denied.

29. CDC has not documented any case of transmission of HIV from a patient to another patient in a dental setting.

RESPONSE: Admitted.

30. There is no documented or proven case of transmission of HIV through aeorsols. (sic)

RESPONSE: Admitted.

/s/ John W. McCarthy, Esq.,
Attorney for Randon Bragdon, D.M.D.

DEFENDANT RANDON BRAGDON, D.M.D.'S ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES DATED MAY 4, 1995

[Caption Omitted in Printing]

The Defendant, Randon Bragdon, D.M.D., by and through his attorneys Rudman & Winchell, answers the Plaintiff's first set of interrogatories as follows:

1. Identify and describe in detail any circumstances under which Bragdon will provide dental treatment in the Bragdon office to a patient with HIV or AIDS.

ANSWER: None when the patient is known to be infected.

2. Describe how Bragdon's Infection Disease Policy operates and is implemented when a person with each of the follow infectious diseases presents at the Bragdon office for dental services or treatment: AIDS, HIV, Tuberculosis, Hepatitis A,B,D, and non A-B, measles and strep throat.

ANSWER: The defined patient groups are not knowingly treated in the office.

3. Describe in detail all infection control procedures employed by Bragdon in his dental practice on September 16, 1994, Bragdon's methods of sterilization of the high and low speed dental handpieces and other instruments, all types of protective wear worn by Bragdon and his staff (including the types and brand names of gloves, masks and protective eyewear), and the methods by which Bragdon disinfected or cleaned any aspect of the dental operatory after each patient visit.

ANSWER: The procedures are described in my blood pathogen standard program and the hazardous materials program. The documents are available in my office for review by plaintiff through counsel.

I cannot recall the names of the variety of brands of gloves, masks and protective eye wear utilized on September 16,

1994. I generally use latex examination gloves. I usually use ear loop protective masks. One employee uses Nitrile type protective gloves. We use prescription and nonprescription eye glasses with side shields.

4. Identify each hospital or institution at which Bragdon had obtained privileges or credentials to use a surgical operatory or other hospital space for dental procedures as of September 16, 1994.

ANSWER: I have obtained privileges in the past. I have performed dental functions at the Bangor Mental Health Institute. However, I did not have privileges at any institution where I could provide services as of September 16, 1994.

5. With respect to each hospital or institution identified in Interrogatory Number 4, state the date on which Bragdon was granted such privileges or credentials and the scope and nature of such privileges or credentials.

ANSWER: I believe I obtained privileges at Bangor Mental Health Institute in the early 1980's.

6. Identify each hospital or institution at which Bragdon has ever applied for privileges or credentials to use a surgical operatory (or other hospital space) for dental procedures, the date on which such application was made, and the results or current status of such application.

ANSWER: Boston City Hospital, 1977, approved for one surgery rotation. Togus Veterans Hospital, 1978, approved for externship. Bangor Mental Health Institute, early 1980's, approved for staff privileges. No notice of termination but operatory no longer maintained. Down East Community Hospital, 1994, pending.

7. If Bragdon did not have privileges or credentials to use a hospital surgical operatory (or other hospital space) as of September 16, 1994, state all facts and identify all documents upon which Bragdon relies to support his contention that he would have provided treatment to Abbott in a hospital surgical operatory.

ANSWER: If the plaintiff desired the services I would have worked with the patient and her physician and hospitals to secure a proper site for the dental care.

8. Specify and describe all medical, epidemiological, dental or scientific facts and evidence upon which Bragdon relies to justify his Infectious Disease Policy on the basis that there is an unacceptable risk of HIV transmission from an HIV-positive patient to another patient in the Bragdon office.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, the Infectious Disease Policy is based on multiple publications, teaching and training. A disclosure of the documents which I have reviewed and which I rely on in developing, formulating, or implementing my Infectious Disease Policy will be made available at the convenience of all counsel at the offices of Rudman & Winchell, Bangor, Maine. I will also advance an expert position in accordance with the Federal Rules of Civil Procedure. Any expert will disclose documents relied upon in advancing the opinion as is required by the Federal Rules of Civil procedure.

9. Specify and describe all medical, epidemiological, dental or scientific facts and evidence upon which Bragdon relies to justify his Infectious Disease Policy on the basis that there is an unacceptable risk of HIV transmission from an HIV-positive patient to a dental worker in the Bragdon office.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

10. Specify and describe all medical, epidemiological, dental or scientific facts and evidence

(including the title and date of any journal article or other publication) upon which Bragdon relies for any contention that this Infectious Disease Policy with respect to patients with HIV or AIDS is necessary because HIV can be transmitted to a health care worker or another patient in the Bragdon Office through aerosols.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

11. Specify and describe all medical, epidemiological, dental or scientific facts and evidence (including the title and date of any journal article or other publication) upon which Bragdon relies for any contention that his Infectious Disease Policy with respect to patients with HIV or AIDS is necessary because HIV can be transmitted in the Bragdon Office through dental instruments, including but not limited to the high and low speed dental handpieces.

OBJECTION: Defendant objects tot his interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

12. State all medical scientific facts and evidence upon which Bragdon relies for this opinion, judgment or belief, if any, that the types of gloves, masks and protective eyewear identified in response to Interrogatory Number 3 are in any way inadequate.

ANSWER. Please see answer to interrogatory number 8.

13. Identify by date, journal and title any publication, research, or study, including but not limited to the Morbidity and Mortality Weekly Report published by CDC, or any publication of the American Dental Association, which Bragdon maintains documents or proves transmission of HIV from patient to dental worker or from patient to patient in a

medical or dental setting.

ANSWER: Please see answer to interrogatory number 8.

14. Specify and describe in detail each and every way in which Bragdon maintains that any of the universal precautions, recommendations, or mandates of the CDC, OSHA or the American Dental Association to prevent the transmission of HIV in dentistry are ineffective or inadequate.

ANSWER: My attorneys will provide expert positions on this issue in accordance with the Federal Rules of Civil Procedure.

15. Identify and describe in detail each and every way in which Bragdon maintains that treating a patient with HIV or AIDS in a hospital surgical operatory reduces, minimizes, or eliminates the risk of transmission of HIV from a patient to a dentist or dental worker in comparison to providing the same dental services to an HIV-positive patient in the Bragdon office.

ANSWER: My attorneys will provide an expert position on this issue. It is well established that a hospital operatory provides a state of the art environment for invasive procedures and safety to staff and patients. For example, air filtration, ultraviolet lights, complete scrub down of floors and equipment between patients and the use of respirators (rather than masks) occurs in a hospital setting.

16. Identify and describe in detail each and every way in which Bragdon maintains that treating a patient with HIV or AIDS in a hospital surgical operatory reduces, minimizes, or eliminates the risk of transmission of HIV from a patient to another patient in comparison to providing the same dental services to an HIV-positive patient in the Bragdon Office.

ANSWER: See answer to interrogatory 15. In addition, in a hospital setting it is likely to have available space for additional assistants to make transfers to the chair side assistant.

17. Specify and describe in detail all reasons not identified in Interrogatory Numbers 15 and 16 that Bragdon believes a hospital or surgical operatory provides better infection control protection than Bragdon can provide in the Bragdon office.

ANSWER: See answers to interrogatories 15 and 16.

18. State the name, job title, job responsibilities, home address and dates of employment of each person employed by the Bragdon Dental Practice from 1980 to present and identify which of those employees was present and working in the Bragdon Office on September 16, 1994.

ANSWER: Randon Bragdon
129 Hudson Road
Bangor, Maine 04401
General Dentist-Sole Proprietor
1978 to present

Judith Bragdon
129 Hudson Road
Bangor, Maine 04401
Office Manager
1978 to present

Cheryl Bell
RFD #1, Box 24
Levant, Maine 04456
Receptionist
1987 to present

Kristin Long
57 Veazie Street
Old Town, Maine 04468
Dental Hygienist
1989 to present

Kimberly Hayward
RR 1, Box 1238
Dixmont, ME 04932
Chair side assistant

1992 to present

Bethany Bragdon
129 Hudson Road
Bangor, Maine 04401
Part-time receptionist
January 1991 - May 1991

Tracey Wren Frost
RR#2, Box 347
Carmel, ME 04419
Dental Assistant
April 1987 - September 1992

Tina Brown
RR#2, Box 200
Dover-Foxcroft, ME 04426
Temporary Dental Assistant
September 1994

Jean LaRochelle
P. O. Box 164
Carmel, Maine 04419
Temporary Dental Assistant
October 1994 - November 1994

Evelyn Hobbs
18 C Street
Bangor, Maine 04401
Part-time Clerical
October 1987 - January 1989

Kelly Emery Estes
P. O. Box 331
Hartland, ME 04943
Hygienist
August 1985 - April 1989

Kimberly Mitchell
1794 Broadway
Bangor, Maine 04401
Part-time Hygienist

February 1984 - April 1986
December 1987 - January 1988

Angela Glidden
707 Hammond Street
Bangor, Maine 04401
Hygienist
December 1987 - January 1988

Linda McBrine
46 Mt. Desert Drive
Bangor, Maine 04401
Part-time Dental Assistant
August 1984 - December 1984
February 1985 - May 1985
October 1986 - August 1988

Laura Young
35 Harlow Street
Brewer, Maine 04412
Receptionist
August 1984 - August 1987

Frances Turcotte
262 Parkview Avenue
Bangor, Maine 04401
Part-time Dental Assistant
March 1987 - April 1987

Tammy Allen Brown
RR #1, Box 105C
East Corinth, Maine 04488
Dental Assistant
September 1984 - February 1987

Denise Cousins
35 Holyoke Street
Monson, Maine 04464
Temporary Dental Assistant
June 1986

Mary Ann Hewes Bjork

P.O. Box 101
Monson, Maine 04464
Temporary Hygienist
October 1985 - December 1985
May 1986 - June 1986

Roxanne Horne
13 J.R. Drive
Lincoln, Maine 04457
Part-time Hygienist
September 1983 - June 1985

Linda Corthell
P. O. Box 141
Pembroke, ME 04666
Temporary Receptionist
January 1985

Michelle Warren
RR#1, Box 1710
Bangor, ME 04401
Part-time Clerical
February 1985 - September 1985

Debra Howell
249 15th Street
Bangor, Maine 04401
Temporary Hygienist
October 1985 - December 1985

Noreen Hashey
RR#1, Box 535
Kenduskeag, ME 04450
Temporary Receptionist
February 1985

19. Describe and state in detail the dates, location, parties to and substance of all communications (written or verbal) between Abbott and any employee of the Bragdon Dental Practice, including but not limited to communications on September 16, 1994.

ANSWER: At some date previous to September 16, 1994 Sidney Abbott made an appointment for the apparent purpose of determining the cost of a filling. Cheryl Bell probably received the call and it was probably made in July or August of 1994. All that is known about the call is that the notation was made in the appointment book the patient only wanted to know the cost of a filling.

In reviewing the medical and dental history Sidney Abbott filled out, I noted that she had checked she was HIV+ and was allergic to Bactrim. I asked her if she had any medical problems. Ms. Abbott said that she had been HIV+ for eight years with no symptoms or problems. I asked her what I could do for her and she said she was wondering how much it would cost to have me do a filling on the lower left. She indicated that she had been advised of the cavity at another office. I examined the carious lesion and did a general examination of her mouth and oral cavity. She verified that a small carious cervical lesion on the buccal of #19 was the cavity she was interested in. I informed her that my fee would be either $35.00 or $45.00 and I would be happy to treat her in a hospital setting. She would be responsible for the hospital fees. I explained my infectious disease policy to her and that I did not feel that the dental operatory was a proper setting for treating patients with serious infectious diseases. She had no questions about my infectious disease policy or what would be involved. She did not indicate that she had any objections. She said that she would think about it and let me know if she wanted it done. On the way out she asked if there was any fee. I told her no. I do not regularly charge a fee in the few instances where the request is simply to inquire as to the cost of a service.

20. Describe in detail all communications (verbal or written) between Abbott and Bragdon, including but not limited to communications on September 16, 1994, and state the name, job title and home address of any person who was present during or witnessed any such communications.

ANSWER: See answer to interrogatory 19. The only other brief communication would have been Cheryl Bell asking the patient to fill out the medical and dental history and general

information form. Judith Bragdon was present during communication with plaintiff.

21. Describe in detail the nature, extent, and findings or results of any dental examination, treatment, or services provided by Bragdon to Abbott, including but not limited to September 16, 1994, including an itemization of all diagnostic procedures and dental treatment performed on Abbott.

ANSWER: There was no treatment except a general examination.

22. Describe in detail the circumstances and conditions upon which Bragdon would have provided dental treatment to Abbott in September, 1994, including filling her cavity, specifying the precise hospital or institution where the treatment would take place, whether Ms. Abbott would have been required to pay for the cost of the hospital facility or surgical operatory, who would pay for any additional staff, special instruments or lab tests which Bragdon claimed were necessary, and any and all plans which Bragdon had in place as of September 16, 1994 to implement a plan of treatment for Ms. Abbott.

ANSWER: I would have expected to treat her at Eastern Maine Medical Center but have since learned that the hospital has not kept up its dental equipment. Ms. Abbott would have been responsible for the hospital charges, any fees her physician might have charged for my consulting with him and recommended laboratory tests. She would not have been charged for the second assistant that I feel is necessary in treating an infectious patient in a dental environment.

23. Identify name, current home and business addresses, and telephone number each witness whom Bragdon intends to call at the trial of this action and state the subject matter and substance of each such witnesses' testimony.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which was prepared in anticipation of litigation or in preparation for trial, and if, therefore,

protected by the work product doctrine.

ANSWER: Trial witnesses will be identified prior to trial in accordance with court orders and the Federal Rules of Civil Procedure.

24. Identify the social groups or populations which Bragdon believes or understands to be at higher risk for HIV or AIDS in Maine and the United States.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

25. Identify by name and address each political, medical, dental, religious, community or other organization, association or political party to which Bragdon has belonged or been affiliated with in any way from 1980 to present, specifying in your answer the nature and extent of Bragdon's role or participation for each entity.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

ANSWER: With regard to medical and dental entities, defendant responds as follows: I do not and have not belonged to any medical associations. With regard to dental associations I am and in the past belonged to the American, Maine and Penobscot Valley Dental Associations. I also have been associated with Academy of General Dentistry, the American Orthodontic Society, the International Association of Orthodontists, International Dental Health Foundation, and International Association of Physicians for AIDs Care.

26. With respect to each such entity listed in Interrogatory No. 25, describe and state any positions, opinions or statements made by the organization or by any member, employee, director, or officer from 1980 to present regarding AIDS or HIV, homosexuality or bisexuality,

including in your answer the title, date, and name of journal, in which any such position, statements or opinions were made.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

27. Identify and describe in detail any occasion from 1978 to present in which Bragdon has provided dental treatment or services to any person with an infectious disease, including but not limited to HIV or AIDS, tuberculosis (active or inactive), strep throat, hepatitis A,B,C and non A-B, syphilis or any other sexually transmitted diseases, measles, mumps, or chicken pox stating the date, the location where the treatment was provided, the precise nature of the dental services or treatment performed, and any infection control procedures utilized which Bragdon did not at the time such services were rendered regularly utilize for patients without that infectious disease.

ANSWER: I have not knowingly treated a patient with serious infectious disease. Occasionally, I have learned after the fact that I had treated a patient with an infectious disease.

28. Identify any person, patient or prospective patient other than Sidney Abbott who has indicated to Bragdon that he or she is HIV-positive or has AIDS and with respect to each such person, state whether Bradgon provided any services to such person, the location and nature of the treatment, any referral made to another provider, and the reason if Bragdon did not provide any treatment.

ANSWER: Plaintiff's counsel is aware of a patient known as "John Doe" who's situation may be responsive to this interrogatory. I do not recall any other such circumstances.

29. Describe all training and education provided by Bragdon to his staff and employees regarding infection control, universal precautions, AIDS, or HIV from 1990 to present.

ANSWER: See answer to interrogatory 3. The information identified in interrogatory 3 includes training and education provided.

30. Identify all dental periodicals which Bragdon subscribed to and regularly read from 1985 to present.

OBJECTION: Defendant objects to this interrogatory on the basis that attempting to respond would be unduly onerous. Without waiving such objection, I have subscribed to and regularly read the following:

Journal of American Dental Association
ADA News
Journal of American Academy of General Dentistry
AGD Impact
MDA Journal

/s/ John W. McCarthy, Esq.
/s/ Randon Bragdon, DMD
/s/ Jurat

SANFORD F. KUVIN, M.D. DEPOSITION EXCERPTS OF VOL. 1, JULY 20, 1995 DEPOSITION

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Q: Is it your impression that Dr. Christianson believes that HIV-positive patients can never be treated for routine dental care in the dental office but should always be referred to?

A: No. I want to be quite careful and candid. I can't speak for what Dr. Christianson thinks. But I do believe that Dr. Christianson feels that HIV patients have not been afforded the type of good care they need, and that her general thesis, without speaking for her, is very much in accord, perhaps not in total accord with Dr. Bragdon. But certainly the conceptual policies are similar.

Q: So it's your understanding that Dr. Christianson thinks that sometimes HIV-positive patients should be referred out of the dental

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office for specialized care?

A: Yes.

Q: But not all the time?

A: I don't know that.

Q: Are you aware of any public health authority that says HIV-positive patients should always be referred out of the dental office for routine dental care?

A: I thought I tried to answer that question earlier on.

Q: Can you answer it now, please.

A: It's my opinion that there are several public health authorities that suggest that all, not all HIV - strike that - that HIV patients should be referred for specialized care under given circumstances.

Q: Are there any that say under all circumstances HIV patients should be referred out of the dental office

A: I know of no -

Q: Excuse me - for routine dental care?

A: I know of no organization that says that all HIV patients should be referred outside the dental office for

routine dental care.

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Q: Do you personally believe that all HIV-positive patients should be referred out of the dental office for routine dental care?
A: I don't think I'm really - I'm not a dentist. And in all candor am not familiar with the vagaries of dentistry as to what goes on in a dental operatory, whether it be aerosol spray or contaminated water lines or other patients in the operatory or people who have cough reflexes who are more sensitive than other cough reflexes and what saliva is being spewed about. I just am not familiar with that.
Q: You referred earlier to some specially designed treatment centers that you had heard about in New York for HIV-positive patients; is that right?
A: I did mention that.
Q: And that was accurate testimony?
A: Would you kindly explain your question?
Q: You're aware of specially designed treatment centers for HIV-positive patients in New York: is that right?
A: I said yes.
Q: And they handle routine dental treatment:

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is that right?
A: To the best of my knowledge.
Q: What's the basis of your knowledge in that regard?
A: Published reports. I've made no site visits, and I don't pretend expertise in these centers at all.
Q: And the published reports?
A: I read Dr. Bragdon's deposition where he referred to several of these centers. In conversations I've had with Dr. Michael Glick - that's not a published report. I'll retract the word "published" - but he told me about centers in the course of just general conversations.
Q: Is it your understanding that special infection control procedures other than universal precautions are followed at these specially-designed treatment centers

when HIV-positive patients are being provided routine dental care?
A: It's my understanding that these centers cater to a clientele where it is understood that all patients are potentially HIV infected, and therefore the level of care is geared to that concept. It's my understanding that the universal

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precautions employed are similar to those employed elsewhere. But it's the intensity and the knowledge that most if not all of these patients in fact are HIV infected, and therefore the intensity of care is so relegated towards that.
Now, having said that, I don't know whether certain centers, whether St. Claire's in New York or the center in Chicago, but I do believe some of them, if not all of them, but some of them perhaps use other engineering methods that are associated with the risk of other germs associated with HIV, in particular TB, where facilities are engineered that could not be accommodated in an accommodation such as Dr. Bragdon's office with reverse air flow, ultraviolet light, HEPA filters, major alterations in the engineering, for lack of a better word, for ancillary care to prevent aerosol transmission of other germs.
Q: Is your opinion in this case based on the understanding that there are specially designed treatment centers where infection control procedures beyond universal precautions are followed when providing routine dental care to HIV-positive patients?

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A: As I said to you before, I don't have specific knowledge of that.
Q: So you're not sure about that?
A: I'm not sure about that.
Q: And in fact some of your information has come from reading Dr. Bragdon's deposition transcript, right?
A: And conversations with other dentists.

Q: On the phone or in person?
A: Over the phone or in person.
Q: And that's the extent of your knowledge of these specially-designed treatment centers?
A: Yes, it s.
Q: Besides Dr. Glick, can you recall any other dentist or person that you've spoken to about specially-designed treatment centers for HIV-positive patients?
A: I've had some conversations with dentists across the nation about the issue of infection control. I'll be happy to give you some of their names that I can remember, but I can't recollect whether it was specifically geared toward the specialized centers.
Q: Please give me the names of people who

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you believe you discussed the specially-designed treatment centers for HIV-positive patients with?
A: I can't recollect specifically other than when I mentioned Dr. Glick to you. But other than - I can't recollect, as I just said to you, whether I discussed the specially-designed treatment centers with these other dentists, although the discussion was involved with infection control I can tell you who I discussed infection control with, but I can't tell whether or not special treatment centers were incorporated in that discussion ...

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... tions by his staff. And yet, this cluster of cases of HIV occurred in Florida. We also know conversely that health care workers have been infected, because blood is a two-way street. And it's not surprising, therefore, that health care workers have been infected from patients. And the CDC lists health care workers that have been infected with HIV.
The official numbers, as you know, are about 42; but there are an additional 91 which are also on the list, six of which are dentists.

Having said that, we know that gloves rip, tear, leak. They're porous. They have many defects to them. And there is not much evidence to show in the literature that a reduction in disease has occurred of great significance since the introduction of universal precautions with barrier techniques.
However, I said before, I'm a great advocate of it, because medical logic suggests that using barriers will prevent disease transmission. In trying to prevent the transmission of HIV in the dental operatory, the use of gloves, the washing of hands in between patients, the double gloving where possible, are all methods of universal precautions to reduce the risk, although the risk is still there. It's significant. It's real. It's a low risk. But it's certainly absolutely real.
And in trying to reduce the risk, the dentists should wear these gloves. And you asked how can this protect. But unfortunately the dentist, as we know, will stick himself or herself

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no matter how hard he or she will try to not stick him or herself. And as you well know, the literature is replete with studies to show that no matter what care responsible invasive health care workers take, they will and are guaranteed to stick themselves, because , after all, they're making human errors.
With regard to other methods of prevention, utilizing universal precautions; the sterilization of instruments; the sterilization of hand pieces, even though there's no evidence that the hand piece has ever transmitted HIV, have been put into use. And in fact many recommendations of the CDC, which in part sets our standard of care, many of their recommendations have been made based on medical logic and not necessarily on hard science.
There's nothing in hard science to show that sterilizing hand pieces prevents the transmission, or indeed there's been no transmission that's been documented of HIV through an unsterile hand piece. But yet the Centers for Disease Control says the standard of care should be

to sterilize all hand pieces. No science behind it

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but medical logic.
And this whole discussion, and please accept this, is based on medical logic. Nothing more, nothing less.
And the problem with dealing with something of this terribly important nature, namely the health of the uninfected, the rights of the uninfected, the right to know, the duty to warn, are all based on medical logic.
Now, to continue with my answer on your question about protecting, using universal precautions, the use of masks is certainly in order. Does it prevent the spread of HIV from the patient to the health care worker? There is no evidence that suggests that.
However, the CDC in its wisdom says wear a mask.
Again, medical logic. Why? Because there's no evidence to suggest that aerosol spray can transmit HIV. But do they know for certain? No.
In fact, if one looks at the very recent issue of the Morbidity and Mortality Weekly Report of just a week and a half ago, you'll find an update on viral hemorrhagic fever. Ebola virus. And it's updated for the United States. And what it says is that there is no evidence of aerosol

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transmission of Ebola fever, however, don't assume that to be totally correct, because we know that monkeys can do it by aerosol.
We know that there's no evidence to suggest that it can occur in man, but be aware and take precautions against it. So it merely is a paradigm of what we don't know and what we're searching for. And I hope and pray that all of us are searching for the better health of the American public.

Q: When you refer to science, you're referring to cases that have been documented; is that right?

A: That's correct.

Q: Do you believe the CDC is a reliable authority on the

transmission of HIV?

A: Certainly I believe the CDC is a reliable authority on the transmission of HIV.

Q: You mentioned that giving birth is a mode of transmission of HIV; is that right?

A: That's correct. Please let me say that it would have to be from an HIV infected mother to a newborn.

Q: So if you're female HIV positive there's

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a substantial risk that your child will be HIV positive?

A: There is indeed.

Q: And you mentioned the exchange of blood and bodily fluids is another mode of HIV transmission?

A: That is correct.

Q: Which bodily fluids are you referring to?

A: Vaginal secretions; semen; body fluids of the abdominal cavity where a surgeon has his or her hands in the cavity and there's an exchange of fluids; the oral cavity, of course, if there are cuts, abrasions; the mucocutaneous entrance. That's not an exchange, but the mucocutaneous surfaces such as the eye, rectum, can receive the virus.
Saliva contains the virus, of course, but by most authorities not in quantitative amounts that are readily transmitted, unless mixed with blood. And as you may know, there have been cases of transmission through sexual acts of cunnilingus which have been documented by the CDC. So whether that's pure saliva or saliva mixed with other things has yet to be determined. But there are,

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for the record, examples of cunnilingus where HIV has been transmitted.

Q: Is your opinion in this case based on the assumption that saliva is a mode of transmission from an HIV-positive person to another person of HIV?

A: I said there's been no evidence to suggest on the face of it that saliva unattended, namely, not mixed with blood,

has been a method of transmission. I would have to add parenthetically, however, that the virus does exist in saliva, but I would also say not in quantitative amounts that have been shown to be transmissible. And, just for the record, there are some anti-HIV constituents of saliva which may negate against the virus itself.

Q: And it's your understanding that sweat is not a bodily fluid that transmits HIV?

A: That's correct. However, sweat is a bodily fluid that can transmit hepatitis B.

Q: So in the dental office the primary body fluids by which HIV could be transmitted would be blood, is that right?

A: Yes. And as I said, and I've already disclaimed saliva in its pure form, but saliva

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mixed with blood certainly.

Q: But it would be the blood that does it?

A: It would be the blood that does it, yes.

Q: In a situation where the blood has some saliva mixed with it, in your opinion would that blood be less likely to transmit HIV because of the anti-HIV qualities in the saliva?

A: No. I don't think that the talking point, as it were, of the anti-HIV quality of saliva is really germane to the over-riding infectivity of blood, the transporter of significant amounts of virions. You could argue how much saliva, how much blood. If it's visibly bloody, it's infections.

Q: Does the transfer of blood from an HIV-positive person to another person who is not HIV positive always transmit HIV to the recipient?

A: No.

Q: In fact most of the times it would not transmit HIV correct?

A: Most of the time it would not transmit HIV.

Q: What are the factors in your opinion that would affect the likelihood of whether the blood

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would transmit HIV?

A: Basically the two factors would be the quantity of virus in the blood and the resistance of the host, of the person that is receiving the HIV, the medical condition, as it were, of the person receiving the inoculum of blood.

Q: When you refer to the quantity of virus, is it fair to say that the more volume of blood you have, the more quantity of virus you're going to have?

A: As a general proposition that would be correct, but of course you could have a small quantity of blood with a very large quantity of virus of a large quantity of blood with a small quantity of virus. I think the descriptive would be viral load.

Q: Assuming you have an HIV-positive patient, is it fair to assume that the larger the amount of blood the more viral load you're going to have?

A: No, that's not a correct assumption. In different stages of HIV, the viral load is different. Therefore a small quantity of blood when there's a high viral load may have more of a

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quantity of infectious agent that a large quantity of blood when the load is lower.

Q: Maybe you didn't understand my question. You have an HIV-positive patient in front of you. If you take a large bit of blood and you put it here, and you take a small bit of blood and put it here, you can assume that you're going to have more virus in the larger sample of blood, correct?

A: That's absolutely correct.

Q: But you're also saying that concentration of virus varies temporally in an HIV patient and also between HIV patients?

A: That's correct.

Q: Are there any factors that correlate with the concentration of viral load?

A: There have been several propositions put forward, none of which are necessarily constant. Early on, in the

early stage of the disease, the viral load is supposed to be higher. If there are cofactors that the patient with HIV has like cofactors meaning other diseases or other health-related matters, that may or may not impact on HIV. These cofactors may reduce the resistance of the HIV patient to some immunological status where

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the concentration of the virus may be elevated.
The concomitant use of antiviral drugs, of course, may alter the viral load. The general health and well-being of the patient, if they're malnourished, if they're diseased from other causes aside from cofactors, may alter the viral load. And of course there's the stage of the disease that the patient is in. If they're in a stage of - their position may change radically where the viral load, particularly if they're near death, their viral load may increase substantially.

Q: Do you agree with the evidence indicating that the viral load is highest at the very beginning of the onset of HIV?

A: I think that's correct.

Q: That would be during the first one to six months?

A Given a broad range of description, because this disease, although it has a bell-shaped curve to it, it has all sorts of extremes.

Q: But is that one-to-six-month range a fair description of the period in which the viral load would be highest?

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A: I would say that would be a fair description.

Q: And the other time at which the viral load would be highest is when a person begins to experience symptoms and develops AIDS, is that right?

A: Yes. You used the word AIDS. AIDS is a descriptive term in my opinion. It's one disease. HIV/AIDS is one disease.

Q: As the HIV becomes more and more symptomatic, the viral load would tend to increase?

A: Yes.

Q: You also referred, you also testified that the medical condition of the recipient would affect the transmission of HIV; is that right?

A: Yes.

Q: I take it the better the medical condition of the recipient the less likely it is that the HIV would be transmitted to the recipient?

A: In general. However, we're dealing with a uniformly lethal disease. With aberrational exceptions, this disease has no survivors; therefore, the potential for transmission is so overriding and is so significant and so devastating

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that whether we're dealing in gradations of highly infections - or let me rephrase that by saying in my opinion HIV is a disease of low infectivity. Having said that, within a premises of low infectivity, there are all gradations of the high end of that low infectivity or the low end. But be that as it may, it's infectious. It's infectious for life. The risk is devastating, and it's real.

Q: You indicated that there are aberrational exceptions to HIV being fatal; is that right?

A: When I use the word "aberrational," I'm saying it's so rare as to be recorded as rare and needs further investigation, because maybe those small number of cases will help us in finding out why these people don't get sick and die and whatever. I only use it in that general context of discovery. Again, we're in a period of trying to unravel this, for lack of a better word, this plague, which is the worst disease to come on the fact of this earth.

Q: When you say "rare." You mean less than 1 percent?

A: Yes.

Q: But I take it your adopting …

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A: That would be true in the best of all worlds. But, as

you may know, more likely than not, the HIV-infected patient as opposed to the general population, as opposed to the non-immunosuppressed population, often will have no symptoms. And the converse, just from a medical point of view, are signs. Symptoms means cough, pain, what have you. A sign is-where there's a demonstrable change in the patient's physical condition.

So the problem with HIV in general is that it is a disease which in essence hides other diseases. And, therefore, the health care worker is left with the rather onerous decision of what to do about such a patient, and particularly where little is known about the medical history because in the State of Maine HIV is not a reportable disease.

Q: Of course if the patient voluntarily discloses that to you, that's not a problem?

A: That's not a problem if the patient voluntarily disclosed it.

Q: And in this case the patient voluntarily disclosed her HIV status to the dentist, right?

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A: Yes.

Q: Is it your opinion that dentists should assume that all HIV-positive patients, regardless of the status of their disease, have TB?

A: It's my position that a dentist should consider that possibility very seriously because of the epidemic proportions of TB that are now engulfing this country.

This is not something to be scoffed about or something to be put into anything else but the most serious of terms.

In Bath, Maine one person transmitted TB to 419 people in one small town in Maine. In several clusters of cases in major metropolitan areas, there has been an epidemic of, not a reactivation of latent TB, but the spread of TB from person to person from HIV individuals.

And everybody, when I say "everybody," people of prominent authority from Dr. Dixie Snider, the head of

TB control division at the CDC, to Dr. Anthony Faucchi to virtually every prominent person in the field of infectious disease control has articulated this warning on a national basis and to health care workers in particular.

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And let me add, that several health care workers have died from TB in metropolitan areas of this country in recent years. So I'm not saying anything other than what is recognized in the scientific world, that we are in the throes of a tuberculosis epidemic, which is in part being driven by HIV.

Q: Are you finished?

A: Yes.

Q: Is your opinion in this case based on the assumption that there is a risk of transmission of HIV involving the hand pieces used in the dental office?

A: I don't know, in all candor, whether that is true or not. There have been experts, Dr. Lewis is one national expert in dentistry who has suggested that. There have been others. Again, I will say to you that the CDC has made it the standard of care to sterilize all hand pieces by heat as opposed to cold sterilization. It is also a reasonable conclusion of medical logic to assume that they are concerned about the transmission, even though no transmission has been proven.

Q: Are the CDC's universal precautions

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designed solely to deal with the transmission of HIV?

A: No. They're designed to deal with the transmission of HIV, hepatitis B and other blood-borne diseases. And let me just parenthetically add that whenever the CDC has issued a recommendation, it's been for HIV, hepatitis B, and other blood-borne diseases. And, therefore, Dr. Bragdon is not just talking about HIV in his infectious disease policy. He is talking about an overview of serious infections, plural. HIV is prominent amongst them, but it's not the only one.

Q: Is your opinion in this case based in part on your concern that HIV can be transmitted through the hand pieces in the dental office?

A: If the CDC has decided in its wisdom that the hand piece should be heat sterilized, then in fact if the practitioner is following CDC guidelines, which is the standard of care, then there would be no risk of transmission of HIV in the dental office through the hand piece.

MR. McCARTHY: Excuse me before you ask a question.

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(The witness and attorney confer.)

Q: You testified earlier that a risk of HIV transmission remained in the dental office through cuts or abrasions despite the use of universal precautions; is that right?

A: Yes.

Q: Could you explain how such a transmission would occur from patient to dental workers?

A: Certainly. If a dentist, Dr. Bragdon is operating on Ms. Abbott and the field is bloody and Dr. Bragdon sticks himself and bleeds, which allows an ingress of blood into Dr. Bragdon and his hand is in the mouth cavity of Ms. Abbott, then Dr. Bragdon runs a risk of contracting AIDS from Ms. Abbott.

Similarly, if Dr. Bragdon cuts himself and bleeds into Ms. Abbott's mouth while she in turn is undergoing a procedure which required or results in bleeding in her mouth, then there will present a potential position of the co-mingling of blood and oral fluids, which will be co-mingled between Ms. Abbott and Dr. Bragdon. I suppose one could hypothesize to the remote that Ms. Abbott could bite Dr. Bragdon.

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But putting that aside as a remote possibility, the main event is the co-mingling of blood in a bloody field where Dr. Bragdon has either stuck himself or cut himself, of if Dr. Bragdon had some lesions on his

hand which were eczematous or some for of dermatitis and his gloves were less than perfect, they were holey, they were unholey, they were ripped, they were torn, they slipped, whatever. In other words, if Dr. Bragdon allowed an entry of blood into his hand through lesions on it, that would be another method.

And then, of course, if Ms. Abbott were in a situation where her cough reflex was stimulated, as all of ours has been in a dental office, and she decided inadvertently to cough and blood went into Dr. Bragdon's eye, Dr. Bragdon would then be subjected through a less common but nevertheless real method of transmission of a blood-borne virus.

So blood, blood is a two-way street. It goes from patient to health care worker. It goes from health care worker to patient. There's nothing unusual about that. It's gone on ever since medicine was invented 5,000 years ago in

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Egypt. And the fact that we're dealing with a uniformly lethal blood-borne virus today is very significant.

It's a tragic disease, as we all agree. And although the health care aspect is not the main event, it is certainly ...

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Q: Any other authorities that your relying on for the proposition that persons with HIV who are otherwise asymptomatic are more likely to get TB than the average person?

A: Well, in the June 16 issue of the New England Journal of Medicine of 1994 - the authors' names unfortunately escape me. There are two articles plus an editorial which clearly articulate not only the authors' opinions, Dr. Snider's opinions, but the references, at least in the dozens which also articulate or rearticulate this opinion about HIV-infected patients having this extraordinary

propensity for getting TB because of their HIV status.

Q: Based on your understanding of these studies that your citing, is the increased risk of TB for HIV-positive patients the same regardless of how symptomatic they are?

A: That's something that is open to medical debate, not debate, but inquiry at the moment. Certainly the more advanced a person's illness is with HIV and the more they are immune compromised, they would therefore logically have a greater propensity toward getting TB. But there is also no

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doubt about it that HIV patients who are apparently feeling well, acting well and not in any advanced state of disease - although by the definition of having HIV means that they're seriously ill. Just having the virus means that you're seriously ill. They too have a much greater risk of getting the disease. But what's equally cogent is that they have a great risk of transmitting the disease, not only getting it but transmitting it to others.

Q: You're referring to TB?

A: Yes.

Q: Is it your understanding that these studies indicate that even if an HIV-positive person has a regular CD-4 count they're more likely to get TB than another person with the same CD-4 count who is not HIV positive?

A: That's correct. And furthermore, the -

Q: Is this responsive to my last question?

A: Yes, just to complete the answer to it. And, furthermore the amount of multiple drug resistant TB amongst this very class of patients, namely the HIV-infected patients, is in much greater proportion than the general population. In other words, the incidence of multiple drug

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resistant TB, which as you know is treatable to the extent of about 20 percent. Under current technology, about 70 to 80 percent of these patients die. The

frequency of multiple drug resistant TB is inordinately large in HIV-infected patients.

Q: Do you believe that HIV-positive patients are entitled to receive routine dental care?

A: Unequivocally.

Q: And you think that can be safely done at least in some settings?

A: Absolutely.

Q: In Paragraph 2 of your report you indicate that treatment of patients suffering from the HIV virus is not a civil rights issue?

A: I believe that.

Q: You think it's improper for the government of the United States to enact civil rights legislation to protect the rights of persons with HIV?

A: No.

Q: Do you think laws doing that are unconstitutional?

A: No.

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Q: You think those laws should be repealed?

A: No.

Q: In Paragraph 5 of your report you state that, "There's ample evidence that HIV is transmissible from patients to health care workers and from health care workers to patients in the invasive health care setting." What evidence are you referring to?

A: I think you left off the last sentence of that paragraph.

Q: I did. I was referring to the first sentence of the paragraph.

A: Okay. But just for completeness, the paragraph was not read in its entirety.

Q: The word "ample evidence" only appears in the first sentence that you choice [sic] to write in your report, correct?

A: Yes.

Q: And I'm focusing on the words "ample evidence" and asking you to explain what the ample evidence is for the rest of that sentence that you wrote.

A: I just want to be quite clear that you haven't read the entire paragraph.

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Q: Well, for the record, I haven't read the entire report.
A: We're talking about a paragraph that has one further sentence to it.
Q: You're absolutely right.
A: Thank you. The ample evidence for blood-borne viruses and other infectious agents such as HIV are transmissible from patients to health care workers and from health care workers to patients is as follows: We have a paradigm of a blood-borne virus of hepatitis B that has been shown repeatedly to be transmitted to health care workers from patients in the thousands. And, in fact, approximately 200 to 400 health care workers die each year, have died in the past each year as a result of hepatitis B transmission from patients to health care workers.
The recent improvement - as you know, I'm chairman of the hepatitis B action group. The recent improvement in the technology of hepatitis B is that there is now for the first time - it's been around for a number of years - the safest, most effective vaccine ever made to prevent hepatitis B. Unfortunately, the utilization of

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that vaccine has not been what it should be.
It's getting better. However, it doesn't take away from the fact that still even in today's world, people are dying needlessly from the transmission of hepatitis B from patients to health care workers. And last year there was reduction, but there were still a significant number of health workers who were getting the blood-borne virus of hepatitis B from their patients and dying from it. Countless thousands, hundreds of thousands have gotten it over the years and have not died, some of which have had no illness or minimal illness, some of which had long-lasting effects of cirrhosis. And others, of course, have gotten primary carcinoma of the liver.
Conversely, within that question that you asked about

ample evidence that blood-borne viruses of infectious agents being transmissible between both the patient and the health care workers and the health care workers and the patient, the converse has occurred where over 300 to 400 patients have gotten hepatitis B from their health care workers who were carriers of hepatitis B.
Now, the field of dentistry has been

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investigated with regard to that, of course. And it was found in the earlier days, a few years ago - and we have to refresh our memory occasionally, I think, that we're dealing with a new disease. HIV only came into this country in 1981. So in terms of modern technology, we've learned that hepatitis B - and, by the way, the chap who won the Nobel prize for hepatitis B discovered it in the '70s.
We're dealing with recent events in terms of medicine. These are not old time diseases. These are brand new emerging diseases of which we are constantly discovering new knowledge virtually every day. We learned that the transmissibility of hepatitis B is highly infectious, 100 times more infectious than HIV, easily spread and much more easily spread than HIV. And knowing that and with all the universal precautions in place that were recommended as the standard of care, still hepatitis B was spread to approximately 300 patients.
It was found that some of these patients were under the care of dentists who were highly infectious with hepatitis B, virtually all

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of them carrying what is called the E antigen which is the most infectious form of the virus. And some of them were removed from practice. Some of them gave up practice voluntarily. And since that time, the dentists have not been recorded, documented at least, as transmitting hepatitis B to their patients.
One would say, therefore, universal precautions

worked. Unfortunately, that's not the case. And in recent times within the last several years there have been other clusters, a total of 33 clusters of transmissibility of hepatitis B to patients when all universal precautions were taken, single gloving, double gloving, all under the scrutiny of the operating room where it wasn't a private dentist's operatory. It was a big time hospital operating room with the scrutiny of scrub nurses, other doctors, whatever, watching the technique, no break in surgical technique. And yet this cluster of hepatitis B was indeed spread. So that is ample evidence in my opinion of the spread of an - that is ample evidence of the spread of a blood-borne disease,

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both between the patient and the health care worker and the health care worker and the patient, reflecting the common sense, logical observation that blood is a two-way street. The method of spread still remains to be determined. Then we move into other blood-borne diseases, HIV.

Q: Let me just clarify that my question was about the ample evidence that supports part of your opinion concerning HIV being transmittable from patients to health care workers and from health care workers to patients in the invasive health care setting.

A: I'll be happy to address that, but I don't think that was the questions originally. You read the blood-borne viruses.

Q: Just to clarify, I'm asking you for all the ample evidence that supports your view that HIV is transmissible from patients to health care workers and health care workers to patients in the invasive health care setting.

A: Fine. If I restrict my answer to your singular question about HIV alone and not other blood-borne diseases of which there are many -

MR. McCARTHY: Just a second. Just

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in case you are so restricting him, I want to be sure that his position is understood, which is the activity in these other fields, for example, hepatitis B, by analogy is relevant to the question of whether there's ample evidence. If you don't want him to give you that information, just, again, that's what you're saying, then he won't.

MR. WEBBERT: I think you're coaching the witness. I think he's fully capable of answering questions. What I asked him was quite clear. What is the ample evidence that supports his view with respect to HIV. If he wants to bring in anything, whatever he wants to say, it's up to him, and that's all I want to hear.

MR. McCARTHY: I'm quite sensitive about lawyers coaching witness. I'm not doing that. It seems like you must not have been paying attention, because that's what he just said about HIV and hepatitis B. But you ask the questions and get the answer. I just wanted to be sure if you were limiting him that later on you won't say, You didn't say that when I asked you before at deposition.

MR. WEBBERT: I think my question is

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quite clear that I'm asking about the transmission of HIV. I am in no way limiting his ability to refer to any other disease or anything in the world he'd like to cite as ample evidence.

Q: And if you want to say that what you just said about HBV is part of your answer, that's fine. Whatever you want to say, it's up to you.

A: By definition what I just said about hepatitis B is part of my answer. And now, if you wish me to limit myself to HIV by the nature of your question, I'll be happy to talk about HIV.

Q: Just to clarify, I'm asking you for all the ample evidence that supports your view that HIV is transmittable from patients to health care workers and from health care workers to patients in the invasive health care setting without in any way restricting

whatever ample evidence you think exists that may concern any disease or anything that you think is important.

A: The ample evidence that supports the transmissibility of HIV from patient to health care worker and from health care worker to patient is as follows: A cluster of cases of HIV transmission occurred in the State of Florida, initially

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involving the first patient that was documented by DNA testing ever who was Kimberly Bergalis. And subsequently there were five others that were all documented as having HIV transmitted from a dentist, Dr. David Acer, to five patients in Florida.

Dr. David Acer was a dentist who was HIV/AIDS infected. And all patients were DNA matched and by documentation were determined to have received the AIDS, the AIDS virus from Dr. Acer. To that there is no disagreement in the scientific literature. The CDC convened a conference in February of 1991 in Atlanta to discuss this finding. The conference was concerning itself with blood-borne disease transmission, including HIV and hepatitis B. The primary source of discussion at that conference which I attended and I addressed was the Florida example and what it meant.

And the CDC at that time came up with estimates that in fact although this was the first documented case as determined by DNA testing, the probability was, according to CDC mathematical modules, that there were up to 128 cases, according

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to the mathematical module employed by the CDC, that probably occurred prior to Kimberly Bergalis. And other statistical efforts were put forward to anticipate what might occur in the future.

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... breaching of the anatomical integrity of the tooth with the gum. That could be anything from simple cleaning of the teeth, to extraction of the teeth, to repair of the teeth, to repair of the gums, to oral surgery of the mouth, to pedicle grafts, to endodontia, periodontia, orthodontia, pediodontia, and all of the above.

Q: You consider the cleaning of the teeth to be an invasive procedure?

A: Certainly.

Q: And you believe that's consistent with the consensus of the medical community?

A: Speaking as a patient, my teeth bleed. And as a patient -

MR. McCARTHY: Excuse me one second.

(Witness and attorney confer.)

A: Please repeat the question and I'll

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answer it more concisely.

(Previous question read back.)

A: Yes.

Q: Do you consider dentistry to be more invasive than other health professions?

A: Yes.

Q: Do you consider dentistry to be the most invasive profession in the health area?

A: Yes.

Q: Do you consider the work of a dentist to be more invasive than that of a surgeon?

A: Yes.

Q: And you consider the standard procedures of a dentist to be more invasive than a person who takes blood?

A: Yes.

Q: In Paragraph 6 of your report, the last sentence, you refer to a policy of the American Medical Association; is that right?

A: The AMA is the American Medical Association.

Q: And in the last sentence of Paragraph 6 of your report, you refer to a policy of theirs; is that right?

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A: Yes.
Q: Do you agree with the portion of the policy that you quote in the last sentence of Paragraph 6 of your report?
A: Absolutely.
Q: Turning to Paragraph 7 of your report on page 2, when you refer to tuberculosis, you're making reference to myobacterium tuberculosis; is that right?
A: To what?
Q: Is that the agent?
A: What?
Q: Myobacterium tuberculosis.
A: I believe you mean Mycobacterium.
Q: Let me point you to Paragraph 18 of your report on page 3. Am I correct that you at the end of that paragraph refer to Mycobacterium tuberculosis?
A: That's what I said.
Q: That's what you're referring to in Paragraph 7 as well?
A: In terms of the offending organism?
Q: Right.
A: Yes.

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Q: What is that?
A: Before I answer that, I would have to qualify by saying that there are other forms of Mycobacterium that are involved other than Mycobacterium tuberculosis.
Q: In Paragraph 7 when you refer to the risk of tuberculosis, are you referring to Mycobacterium tuberculosis?
A: Not necessarily only Mycobacterium tuberculosis.
Q: What other form of tuberculosis are you referring to?
A: Mycobacterium aviam intracellulare complex.
Q: Anything else?
A: No.
Q: The second variety you just discussed, how is that transmitted?
A: Mycobacterium aviam complex?
Q: I'm going to call that the second type; is that okay?

We'll refer to that as the second type?
A: It might be easier to call it a non-tuberculosis form of Mycobacterium, because it

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is not tuberculosis.
Q: If it's not tuberculosis, are you sure that you're referring to it in Paragraph 7 when you talk about the risk of tuberculosis?
A: I guess it's partly the way I understood the question and when you injected the word Mycobacterium. If we restrict it to just tuberculosis, we're talking about only Mycobacterium tuberculosis. And I'll apologize for going off on a tangent with Mycobacterium aviam complex.
Q: I'm trying to find out what you're referring to in Paragraph 7 of your report.
A: That is Mycobacterium tuberculosis.
Q: Solely?
A: Solely.
Q: What is that?
A: What is Mycobacterium tuberculosis? It's a bacteria. It's classified as an acid-fast bacteria which means staining technique. It's a bacteria which is the most prevalent cause of bacterial death in the world today. 3 million people die of tuberculosis globally each year. 8 million become infected. And it is a very rapidly

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expanding epidemic, not only in the United States but globally, primarily linked to the global pandemic of HIV.
Q: Let me direct -I thought you were finished.
A: You asked what's tuberculosis. Tuberculosis is spread by droplet infection. It is casually spread. It can be spread by sneezing, coughing, spitting, even laughing or speaking loudly, if one understands that it's spread by the droplets that are spewed out from the mouth. It can also be spread by other methods which are far less common. It can be spread by blood.

It can be spread through draining sinuses, lymph glands, all sorts of lesions. But the primary spread is through the pulmonary, through the lungs and in droplet form, and I might add through laryngeal tuberculosis as well. It affects in the United States - about 150 million people in the United States are infected with the Mycobacterium tuberculosis germ. And the vast majority of these people are in what is called the latent face [sic].
I don't know whether you want me to

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go on with this or is that enough, because if you wish for me to go on, it would be a long discourse about tuberculosis. But I'll leave it up to you what questions you would like to ask.

Q: What is the latent phase of tuberculosis?

A: The latent phase of tuberculosis is where the germ resides in the body in a non-active form and lies dormant. It's an infection for life, and like HIV or herpes, it's there for life. And it can reactivate itself under given conditions.

Q: And you said that approximately 150 million people in the United States have some form of tuberculosis?

A: Have active TB.

Q: Which is the same as the latent variety?

A: Yes.

Q: And when a person has the latent or inactive variety of tuberculosis, they are not contagious; is that right?

A: They are not contagious.

Q: And approximately how many people in the United States currently have active or contagious TB?

A: The estimate is that about 10 percent or

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close to 10 percent, anywhere between 7 to 10 percent will eventually activate into an active form of TB. When and if that occurs is dependent on the condition of the patient. But if one, for example, if we have a resident HIV population which CDC affirms is

between 1 and 1 and a half million patients, then it can be assumed that about 100,000 of these patients have TB. That's about 10 percent. And a significant proportion, as I mentioned earlier, of active TB emanates from HIV-positive patients.

Q: So it's your estimate that 10 percent of the persons with HIV have tuberculosis?

A: Latent tuberculosis.

Q: So 90 percent of the persons with HIV don't have any form of tuberculosis?

A: That's the best guesstimate. But in fairness, because HIV is not reported in 25 of the states - there's only one state in the nation, namely Connecticut, that keeps registries on both HIV and TB. So it is correct to say that the incidence of TB is really unknown in HIV individuals because of confidentiality laws.

Q: For purposes of your expert opinions in

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this case, what assumption if any are you making about what percentage of persons with HIV have some form of TB?

A: A very large proportion of patients with HIV have Mycobacterium avian complex. It's a Mycobacterium, same genus and can cause serious disease. It's also a precursor of TB, Mycobacterium tuberculosis. Although it's a different germ, it's in the same family. There is no reliable statistic, unfortunately, about the incidence of bona fide TB in the HIV community because of confidentiality laws. And I can't give you that answer, because I don't know that. But what I can give you -

Q: If it's responsive to my question, please give it to me.

A: It is responsive to your question. What I can give you is the fact that a significant number of new cases of TB are coming, are emanating from the HIV community. And, furthermore, it's not just a reactivation of this latent form that I've described to you. It's actually transmission from person to person, with a significant portion being, with a significance [sic] proportion of multiple drug

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resistant cases being within the HIV community.
Q: Is it fair to say that based on current scientific knowledge, most people who are HIV positive do not have tuberculosis currently?
A: Yes.
Q: And it's your testimony that people who are HIV positive are more likely to become infected with tuberculosis than the average person; is that right?
A: Yes.
Q: And it's your testimony that people who are HIV positive are more likely to become infected with tuberculosis than the average person; is that right?
A: Yes.
Q: Any other groups fall into the category that renders them more likely to have TB than the average population group?
A: By definition, the definition of HIV is the relentless destruction of the immune system. Therefore, anything that destroys the immune system would open up the patient to opportunistic infections, including TB. Having said that, that group of individuals, be it cancer patients, Hodgkin's disease, patients on suppressive therapy for whatever cancer, the elderly, people who live in shelters, that type of situation does not present with the extreme immunosuppression.
These people are immunosuppressed,

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but is does not present with the extreme immunosuppression, relentless destruction, the total disruption of the immune system by HIV where CD-4 cell counts fall to anything approaching zero. That you do not see in the immunosuppressed other groups. Are they more susceptible, yes. Are they as susceptible, no.
Q: Do African Americans have a higher incidence of TB than the average population in the United States?
A: I believe they do.
Q: Do inner-city residents have a higher incident of TB

than average?
A: Yes.
Q: Males have a higher incidence of TB than women?
A: Yes.
Q: Immigrants from third-world countries have a higher incidence rate of TB than average?
A: Yes.
Q: And there are people who are HIV positive who have normal CD-4 counts, correct?
A: Yes.
Q: What assumptions are you making if any,

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about the number of people in the United States who currently have TB in the active phase.
A: Would you kindly rephrase your question in more specific terms? I don't know what you're aiming at.
Q: How many people do you think currently live in the United States and have active TB?
A: The number of cases that were reported last year, if that's what you mean, was of the order of about 30,000. I maybe off by a few thousand, but between 25,000 and 30,000.
Q: That's the total number of people in the United States having active TB last year?
A: I believe it's in that order. As I said, I'd have to look up the figures. They're easily researchable, but it's of that magnitude.
Q: And most of these people are not HIV positive, correct?
A: Most of those are not HIV positive.
Q: You agree that a dentist needs to be alert to the possibility that a patient may have active TB?
A: Absolutely.
Q: And a dentist needs to be trained in

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identifying persons who are likely to have TB, correct?
A: That is correct.
Q: And what sorts of things should a dentist be looking for

when screening patients for active TB?

A: Well, what they should be looking for and what they're trained in, you can't look for something if you're not trained. And in my opinion the field of dentistry has been remiss and deficient in the field of infectious disease training. Having said that I won't belabor the point unless you ask me to, but having said that the dentist has to employ the skills, judgment and knowledge of how TB works, what its ramification are, how it impacts on a patient that has other diseases like diabetes or a host of other diseases.

So he or she will be called on to exercise their judgment about a serious, casually spread disease that in my opinion they are is not equipped to handle. Even though Dr. Bragdon, who is educated more than most, has the highest of intentions to help his patients, but by his very

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training or lack of it he is incapable without help, without expert help, to evaluate patients properly who have the propensity for TB.

Q: So you think Dr. Bragdon should consult with an outside expert concerning all the groups that have a higher than average risk for TB with respect to whether that person should be referred for TB treatment?

A: No. If you're referring to the groups with HIV, yes, he should consult with outside experts with regard to TB, most certainly. With regard to a host of patients that everyone sees in their everyday practice who are potentially immunocompromised, there are all gradations of immunocompromised patients.

And the ordinary patient who is immunocompromised, the elderly, the patient with diabetes, the patient who had Hodgkin's or whatever, these are not your high-risk patients. They are at higher risk than those who are not immunocompromised, but they're not at the enormous risk of 40 times of the general population that the HIV patient is, because of basic definitions and common sense.

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The HIV virus is the relentless, is the key word, is the relentless disruption of the immune system. Immunocompromised patients are not relentlessly being destroyed as far as their immune system is being destroyed.

Q: Do all people who test HIV positive have a destroyed immune system?

A: No.

Q: It might take 15 years, right?

A: It might take two.

Q: It might take 15, right?

A: It might take 15.

Q: When Dr. Bragdon gets a patient who is not in any of the risk groups, should he make some effort to screen for active TB?

A: Are you suggesting no one in a risk group, even HIV? You said in no risk groups.

Q: He has a regular patient who's not in any of the risk groups for having higher than average incidence rate of TB. Should he still be alert and screen for active TB?

A: Including HIV?

Q: When Dr. Bragdon sees a patient, should he always screen for active TB?

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A: No.

Q: And how does he know when not to screen for active TB, in your opinion?

A. Dr. Bragdon is capable of taking a history. He's capable of inquiring about the complete medical history of the patient that he is treating. And the whole art of dentistry and medicine is primarily an excellent history followed through with appropriate, in the case of dentistry, procedures.

And to divorce one from the other would be the worst of all worlds in that you can't computerize a judgment of a history. And Dr. Bragdon will have to rely on his good judgment as to whether a patient is in need of such testing or whether the patient needs a test for

syphilis or whether the patient needs a test for whatever.

Q: When exercising your good judgment, don't you follow some protocols or standards when exercising that judgment in screening for active TB?

A: If you're going to screen for active TB, yes.

Q: And you don't think Dr. Bragdon should be

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screening all his patients for active TB?

A: No.

Q: If he wanted to screen for active TB, what should he look for?

A: Again, from a medical point of view, you look for symptoms and you look for signs.

Q: What are the symptoms and signs of active TB?

A: Active TB might present itself with weight loss of unexplained origin, night sweats, cough, signs of anemia. Active TB may present itself with a person who is spewing up blood, called hemoptysis. Active TB may present itself with extrapulmonary symptoms or signs that relate to other organs. And, of course, active TB may have signs that are associated with laboratory tests, namely a tuberculin test which is positive.
In the case of immunosuppressed patients it may be negative even though the patient is sick. Or the patient may culture out TB on appropriate testing for the germ itself by culture techniques. And those are the main arenas. The chest X-ray may show something if there is a pulmonary lesion. It may not, even though the

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patient has active TB. And particularly in the HIV-infected individual, negativity does not preclude an active case of TB.

Q: Is it your opinion that a dentist should assume that every HIV-positive patient has active TB?

A: It's my opinion that a dentist should assume that every HIV-positive patient has the potential to have active

TB.

Q: And if an HIV positive patient presents with no other signs or symptoms of active TB, in your opinion, how should that dentist proceed with respect to that patient?

A: That's a judgment call, and there's no protocol written for that. The CDC says that if you suspect active TB, then you should refer that patient for expert treatment. That's what the CDC says. How you suspect that is obviously on nobody's computer screen. It's in the mind of the health care giver, and I can't answer that by any quick fix other than that it's in the judgment of the educated practitioner.

Q: Is there any standard or factors that should inform the wise exercise of that judgment?

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A: Yes, if there were signs or symptoms of TB.

Q: I just said assume there are no signs or symptoms of TB.

A: And there are no standards for that except if the patient is at a very high risk. And by public health definition, an HIV-infected patient is a high-risk patient for TB. Therefore, it will depend on the practitioner to decide whether or not he or she wishes to screen that patient or whether he or should say, Be screened by your local doctor or by your public health authority or whatever.

Q: If the HIV-positive person has a primary physician who is handling their HIV status, could the dentist just call that person to get their opinion about whether this person has active TB before proceeding?

A: Certainly if the patient will agree to that arrangement.

Q: Another possibility would be ask the person to have a TB test; is that right?

A: Certainly.

Q: Are those steps ones that should be taken

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before the dentist uses all the precautions that are indicated before a patient who is known to have active TB --

A: Excuse me, but your prefacing it by saying skin test. Did you not say to do a tuberculin test first?
Q: Calling the primary physician regarding the status of having a TB skin test, are those steps that should be taken before one starts using all the infection control procedures that are designed for a patient who is known to have active TB?
A: Yes.
Q: Most forms of active TB are treatable; is that right?
A: Most forms are treatable.
Q: If it's treatable, that can be rendered noncontagious within two to four weeks; is that right?
A: It can be rendered noninfectious within a period of weeks, yes.
Q: Let me ask you to turn to Paragraph 8 of your report. How did you calculate the risk of transmission of HIV from an HIV dental patient to

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the others in the dental office?
A: That wasn't calculated by me. If was calculated through many investigators. And it's been recorded in publications I've given you and I dare say others that the risk of transmission is about 0.5 percent or namely about one out of 250 needle sticks or thereabouts.
Q: So are you referring to in Paragraph 8 of your report where the studies concerning the risk of transmission of HIV on a dental or health care worker has an accidental needle stick with a known HIV-positive patient; is that right?
A: Yes.
Q: And that's all you're referring to in Paragraph 8?
A: That's all I'm referring to.
Q: Let me ask you to read Paragraph 10 of your report. In the second sentence you state your opinion that universal precautions are unreasonable with respect to Dr. Bragdon because he is unable to deal with all the associated risks of HIV transmission in his office. To what risk of HIV transmission are you referring?
A: As I just articulated under No. 8 those

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were referring to needles sticks, of course, only. And in No. 10 the risks, of course, can extend itself to cuts, to coughing of blood, which would impact on the mucocutaneous surfaces, whether there could be an opportunity for blood-to-blood or blood-to-bodily fluid, the two-way street between Dr. Bragdon and Ms. Abbott.
And the associated risks in that context as I mentioned before are the tearing of gloves, the cutting of gloves, basically the intervention of blood to blood through whatever mechanism, be it a bleeding tooth socket with Ms. Abbot, an inexplicable nick in her gums and the puncture of Dr. Bragdon's gloves, almost any scenario you can think of in the cavity of Ms. Abbott's mouth that would interact with Dr. Bragdon's blood. And Dr. Bragdon can make mistakes.
Q: Are those all the risks of HIV transmission that you believe render it unsafe to practice general dentistry with an HIV-positive patient in a dental office?
A: Those are the known risks that I would consider. The unknown ones, I haven't, none of us

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have learned about yet. But I would be remiss if I didn't indicate to you that those unknown risks, because a paradigm of other blood-borne virus, hepatitis B, clearly exist.
Q: You're positive that these unknown risks exist?
A: I'm positive that they exist, yes.
Q: And that's part of the basis for your opinions in this case?
A: Yes.
Q: These risks of transmission of HIV, do they also exist when a dentist performs general dentistry work on an HIV-positive patient in the hospital?
A: They do.
Q: But you agree that it's reasonably safe for Dr. Bragdon to perform general dentistry work on an HIV-positive patient in the hospital?

A: I believe it's generally safe with a reduced risk.
Q: How is that risk reduced in the hospital?
A: It's reduced in the hospital firstly because Dr. Bragdon has the time to deal with that patient. And time is a critical factor in this,

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shall we call it, debate, because Dr. Bragdon sees an average of 20 to 40 patients a day. In all fairness to Dr. Bragdon, being the careful, astute dedicated doctor that he is, cannot do justice to an HIV-infected patient in his office with 15 patients waiting behind that patient.
The time factor which is in concert and compliments the comfort and confidence factor are absolutely essential to Dr. Bragdon carrying out universal precautions in a hospital setting with the confidence that he's doing the right thing and not causing injury to himself or to his patients.
Q: Any other ways in which performing general dentistry work in the hospital reduces the risk of HIV transmission?
A: No.
(Witness and attorney confer.)
MR. WEBBERT: I'm greatly concerned about this repeated practice of having conversations after I ask questions. And in particular I'm concerned that he's going to backtrack on his last answer, which was quite unequivocal, after consulting with his counsel. I

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request you not do that; and if he does it again, I'm concerned we're going to have a dispute if he changes his testimony in the future.
MR. McCARTHY: I believe I have a right to consult with my client. I believe I have a right to ask for a break when there's no question pending. I have consulted with my client. Putting that aside, I have the right to consult with my client. If you think I don't, we really should discuss that, because I don't have any

doubt but I have that right. As one lawyer said, I'm not a potted plant.
MR. WEBBERT: Does that mean you can do anything that you want?
MR. McCARTHY: No. It means I can talk to my client when there's no question pending. I might as well go home if I can't.
MR. WEBBERT: There are precedents that indicate you're not supposed to coach the witness during deposition. You should prepare him beforehand. And I'm indicating for the record my concern about that repeated practice and my concern that his testimony is going to change based on the conversations with counsel. I have no objection to

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the distinction between going out of the room and doing it in here. That's not the point.
MR. McCARTHY: All right. Let's take a break. I'll go out of the room and talk to him. If you want it done that way, that's fine.
MR. WEBBERT: I just made it clear that's not the way I want it done.
MR. McCARTHY: I'm taking a break, ...

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...
A: No.
Q: Why are you not a member?
A: It's another organization like the AMA

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which you pay your money and you join. And I just am not - well, it does no service to me to join innumerable organizations with no meaning as far as I'm concerned as to the productivity that I can perform at this stage in my career.
Q: Or for the last 35 years, correct?

A: Well, yes, in the sense that I'm a free individual that chooses what I feel is best to serve the public or public policy.
Q: That society has been around ever since you've obtained your medical degree, right?
A: Certainly.
Q: And you've never chosen to become a member; is that right?
A: That's correct.
Q: Were you ever elected a fellow of that organization?
A: You can't be a fellow if you're not a member.

MR. McCARTHY: What organization are we talking about?

MR. WEBBERT: Infectious Diseases Society of America.

Q: Is that right, Doctor?

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Is it fair to say that the National Foundation for Infectious Diseases is primarily a fund-raising organization?
A: No.
Q: You're the chief of tropical medicine at the Seton Hall University Graduate School of Medicine; is that right?
A: Yes.
Q: How large is the tropical medicine department at that institution?
A: The tropical medicine department is basically me. They wanted expertise to teach residents.
Q: So I take it you're both the chief and indian, and there's nobody else around?
A: That's basically correct.
Q: And what do you do as chief of the tropical medicine department?
A: On a demand basis, I lecture to the residents at the graduate school about infectious and tropical diseases.
Q: Average of what, once a year or less?
A: Something of that magnitude.
Q: And that's for a couple of hours that you lecture?

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A: Yes.
Q: Do you receive any salary at all for your position at Seton Hall?
A: None at all.
Q: Have you had any regular patients since 1986?
A: No.
Q: Have you been consulted with about the care of patients since 1986?
A: No.
Q: Have you ever treated any HIV patients?
A: No.
Q: Have you ever treated any patients with TB?
A: Yes.
Q: When is the last time you did that?
A: Prior to 1986.
Q: Did you treat them in your office?
A: Some.
Q: Did they have active TB?
A: Some.
Q: What precautions did you take in your office when you were treating patients with active TB?

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A: Well, once I knew they were active, then I would treat them in a hospital, once the diagnosis was made on an outpatient basis. I would not treat a patient on an ambulatory basis with active TB in those times.
Q: So once you diagnosed that it was active TB, you only saw them in the hospital?
A: That's correct.
Q: And what precautions did you take in the hospital with respect to infection control?
A: Mask, gown.
Q: Any other precautions that you personally took?
A: No.
Q: Any other precautions that were used to reduce the risk of transmission of active TB?
A: Not in those days.
Q: In the capacity that you've served since 1986, do you have occasion to interact with HIV-positive patients?

A: Yes.
Q: Do you take any infection control precautions when you interact with those patients?
A: Yes.

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Q: What precautions do you take?
A: Wear a mask, gown, gloves.
Q: When did you start taking those precautions?
A: Early on in the epidemic. I would say from '85 onwards.
Q: Did you wear a mask, gown and gloves when you interacted with Kimberly Bergalis after you knew she was HIV positive?
A: No, I did not.
Q: Why not?
A: Because in those days of knowledge, the concept of TB, which was the only concern, was not as flagrant or as overt as it is with today's state of knowledge. And I may have misstated by saying I wore a mask after '86. It may have been '90 or '92, somewhere in that area..
Q: If you were consulting with Kimberly Bergalis today, what precautions would you take when examining her?
A: I would wear a mask, gown and gloves.
Q: Any other precautions you would take?
A: Well, I would suggest that I would examine Kimberly in a hospital setting which

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provided for the same type of care that Dr. Bragdon is aiming toward for HIV-infected patients, not necessarily aimed at the HIV only, as mentioned to you. The time factor is a very important one. But also for the concurrent factors, reverse air flow, UV light, the possible use of respirators, in order to protect the HIV-infected patients of what we know today, complications that we didn't know about yesterday.
Q: So if you were a medical consultant on an HIV-positive person today, you would only see them in the hospital?
A: Not necessarily. Not necessarily.

Q: It would depend of how likely you think it is that they have active TB?
A: Yes.
Q: What sort of factors would inform your judgment in that regard?
A: That's again my judgment. And this is the art of medicine, not the science of medicine. And it's predicated on my -- you asked about me -- on my training, my experience. Although I quite rightly told you I've treated no HIV patients, I've seen hundred of them, not treated them, but

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hundreds. And I've seen them around different parts of the globe.
The ability to deal with patients at any given time and the risks one is willing to take as a physician are judgment calls. You'll find some physicians that work in very prominent TB hospitals that wear no masks. And when asked about it they'll say, "Well, I should, but I don't."
Q: What factors should inform a responsible health care worker's decision about whether to treat an HIV-positive patient as if they have active TB?
A: It's really a judgment call as to where the physician feels that HIV patient is in terms of - although all HIV patients can have TB, not all HIV patients are created equal. And it comes down to an exercise in judgment.
Q: And should that judgment be informed by an individual assessment of the factors peculiar to the particular HIV-positive patient the health care worker is dealing with?
A: I'm sorry, rephrase that.
Q: When the dentist or health care worker is making the judgment about whether or not to treat

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an HIV-positive patient as if they have active TB, should they attempt to make an individualized assessment of the particular factors relating to that

patient?
A: Yes.
Q: For example, you would look for symptoms of active TB, correct?
A: Yes. You would look for symptoms and signs of active TB. But if a sign can only be demonstrated by a chest X-ray, which you don't have in your dental office, and if you really suspect this patient of having active TB, then it's incumbent on you to get this patient to a setting where that can be carried out.
You might say, Have your local GP do it or have someone else do it. Have an infectious disease specialist do it. But if I were a conscientious dentist like Dr. Bragdon and I wanted to follow through my patients from beginning to end for their dental well-being, then I would want to follow them into a setting where I could treat them as a complete patient. And the word complete whether you spell it l-e-t-e or l-e-a-t, has a great significance to it.

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The completeness of medical care by Dr. Bragdon I think is one of his most outstanding attributes. I passionately believe that. And I think he's entitled to that judgment of completeness in following through his patients. Is HIV in a hospital setting necessary for the HIV to have reverse air flow, UV lights, all sorts of respirators, no. But the possibility of other infection that is high on the list of Dr. Bragdon's hit list is very important.
Now, there are certain things that I'm not qualified to talk about and Dr. Bragdon is, namely about scrubbing floors, about having second assistants because there's less interchange of instruments, about all these surgical aminities [sic] that he feels are a necessary prerequisite to a hospital setting. I'm not knowledgeable about that arena that he deals in every day.
But I would absolutely support his right to judge that patient, even if it's to err, as the AMA says, on the side of being overly cautious. Why doesn't he have the right to be overly cautious in favor of himself or the

patient if that's his good judgment?

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Q: Are you referring to the AMA policy that you quote in Paragraph 6 of your report?
A: Yes.
Q: That's the one that says the doctor should err on the side of patient protection?
A: Yes.
Q: Is your expert opinion in this case based on the assumption that Dr. Bragdon in good faith wants to treat HIV-positive patients?
A: Yes.
Q: And that he has made good faith efforts to locate off-site facilities that will enhance his ability to take care of HIV-positive patients?
A: I don't know the extent to which he has located off-site facilities. In all candor, I know he has drawn a blank on certain attempts to locate off-site facilities as evidenced by the only documentation I have, which is his deposition. But, do I believe he is serious and passionate about treating HIV patients just like every other patient, absolutely.
Q: And that's an important assumption in your expert opinion.?
A: Yes, it is.

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Q: And you agree that Sidney Abbott deserves to get her dental care taken care of?
A: No question about it.
Q: And that doing that is an important goal of the dentist?
MR. McCARTHY: Object to the form of the question.
A: Well, Sidney Abbott can't have her dental work done without a dentist. So, therefore, it's not only a goal it's an obligation of a dentist to perform that. I have no problem with that at all. However, I do have a serious problem with the inability of Dr. Bragdon to exercise his judgment in taking care of Sidney Abbott.

Q: But you agree he has an obligation to make sure she gets her dental needs taken care of?
A: Absolutely.
Q: And that can be done without exposing him to an unreasonable amount of risk?
A: I think the risk is real to Dr. Bragdon. He is willing to take that risk. He wants to take it under the maximal protection to himself, his patients, his staff and for the betterment of the patient. How can you argue about discovery about

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medical knowledge of a patient? And if you go in for an examination and you do X, Y and Z exams and they're superfluous, you would normally say. Well, I'm glad you found everything was negative. The purpose is in the form of insurance. We don't want to exercise our life insurance policies tomorrow. We want to stay alive.
Q: But you agree that that routine dental treatment can be provided safely to HIV-positive patients?
A: I believe that routine dental treatment can be provided to HIV-positive patients, but always, because of the nature of HIV, with a degree of risk. The risk is low. The risk is in most cases preventable. But the risk looms very large if you don't have the protection that Dr. Bragdon or anyone else providing health care is deserving of to protect himself and the patient.
Q: But you're not taking the position that it's so inherently dangerous to provide general dental care to HIV-positive patients that dentists should not be required to provide such care?
A: O, no. I agree with that.
Q: What is the Sanford F. Kuvin Center for

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the Study of Infectious and Tropical Diseases?
A: The Sanford F. Kuvin Center for the Study of Infectious and Tropical Diseases is an official center for research at the Hebrew University Medical School

in Jerusalem, Israel. It …

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… me about the Morvan case and would I give them a report, which I did.
Q: Is it possible that you called up the attorneys first to initiate that relationship?
A: Good lord, no.
Q: You're positive about that?
A: I'm not only positive, I'm certain.
Q: Let me ask you to look at what we've marked as Kuvin Deposition Exhibit 2. It's a report that the defendant provided us earlier in the case.
A: Yes.
Q: You've reviewed Deposition Exhibit 2

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carefully in the past, correct?
A: I didn't quite hear you.
Q: You've reviewed this report carefully before today, correct?
A: Yes.
Q: Do you agree with everything in this report?
A: Not necessarily.
Q: In Paragraph 2, the report asserts that HIV is highly infectious. Do you agree with that?
A: That's the not necessarily.
Q: You disagree with that?
A: I disagree with that.
Q: In Paragraph 4 there's a discussion of regular monitoring of CD-4 cells. You believe that's indicated when a dentist provides general dental services to an HIV-positive patient?
A: I think it is. I think it's a meritorious recommendation. Again, this is a judgment call. It is certainly a recommended recommendations for treating an HIV patient outside of a dental setting. And if the dentist is coerced, as he is under current circumstances - I hope it will change - but if he is coerced into treating a

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patient with HIV with the same medical obligations, then he too has to follow those same general parameters of testing a patient for CD-4 cell counts, because he too is really being made in to treating a dental patient as a medical patient. And as I indicated to you before, I think it's inappropriate, unfair, unwise and to the worst detriment of both the caregiver and the patient.

Q: If a dentist has a patient who comes in who is HIV positive who indicates she has a primary physician who is handling her HIV condition, what need is there for the dentist to do his own CD-4 testing?

A: Well, I can't give you - and I don't want to sound facetious. If I went in to a doctor and I complained on chest pain, and he said, "Go see a specialist." And the specialist said, "Well, why are you telling me that? You already told it to the first doctor." It's the transfer of responsibility then moves on to Dr. Bragdon because he is then in essence the primary care doctor, not legally. But if he's going to be dealing with diseases like TB, cytomegalovirus,

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staph, strep, toxoplasmosis, whatever the ramification may or may not be, he is put upon to learn as much about that patient as he possibly can. And a CD-4 cell count in today's technology is one of those parameters.

Q: It's your opinion that for a dentist to provide competent, general, routine dental services to an HIV-positive patient, that they must take over the primary care of the HIV condition and all its possible manifestations?

A: No. I don't think they should take over the primary care. But when that patient comes under their care, then they are the chief. And what Dr. Bragdon, unless I'm misconstruing this whole case, what Dr. Bragdon wants to do is to continue to treat that patient under his care, provide dental treatment. But in order to do that, he wants to do it in a setting where the expert care may

be available. But he's still in charge of the dental aspects. But it's being put upon him to deal these other problems if they arise.

Q: Why would a dentist need to know the CD-4 count to take care of a cavity in an HIV-positive patient?

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A: Well, the CD-4 count is merely a reflection of the immunocompromised state of the patient. And if a CD-4 count is at abnormal levels for whatever reason, it means that Dr. Bragdon has to be cautious about what diseases are floating about his operatory from himself, his staff, his patients, so as to not put his patient in jeopardy; and, secondly, to worry about what the patient has in addition to her HIV that may put him in jeopardy. Again, it's his right to know what harm can befall him and what harm can befall the patient, because this is a two-way street.

Q: Do you agree with Dr. Bragdon that there should be annual testing for TB of all HIV-positive patients?

A: Yes, I do.

Q: If they had a recent test that was negative, would that indicate that the patient could be treated as if they did not have active TB?

A: No.

Q: Do you agree with him that there should be an annual test for syphilis of all HIV-positive patients before a dentist performs routine dental care on that patient?

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A: I don't feel uncomfortable with that. I certainly don't feel it's obligatory. The concept is that if the CD-4 cell count is low, the syphilis will progress at an abnormal rate of infectivity, as it were, as would any germ. In other words, if the CD-4 cell count is compromised, syphilis, TB, CMV, toxoplasmosis, anything you can think of will put the patient at greater risk. Syphilis happens to be communicable to other people. I don't feel uncomfortable. I personally don't see it as

obligatory to add it.

Q: Given your concern that HIV-positive patients can test negative for TB and still have active TB, shouldn't we quarantine all HIV-positive patients in this country?

A: No. I'm absolutely opposed to quarantining all HIV patients in this country, because HIV is not spread casually. And TB is. Should we quarantine TB patients? They are quarantined under the law, and that's the rub. Why isn't the law applicable to HIV the same way it is to TB? So, no, I clearly do not see any need to quarantine a patient with HIV.

Q: Unless they test positive for TB?

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A: And only then if they fail to take their medicine. And then only then if they take their medicine and they-re multiple drug resistant.

Q: If you have an HIV positive patient, even if they test positive for TB, you can treat it and then give then the routine dental care in the dental office, right?

A: Yes, you could.

Q: Turning to page 2 in the report, it lists a number of things -

A: Before I leave that, you can give them the routine care in the dental office, if the presumption is to be followed through to its correctness, the ability to diagnose the TB would be done in a hospital setting. And it would therefore be cost effective, shall we say, to treat the patient while they're in the hospital setting for the dental problems after they've been rendered noninfectious to TB.

Q: Wouldn't it be cheaper to provide dental care in a dental office than in a hospital?

A: On the face of it, of course.

Q: Isn't it cheaper to wait the two weeks to render the TB inactive and then do the treatment?

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A: It could be, or it could be a lot more expensive, depending on the patient you're dealing with. Again,

we're back to judgment.

Q: Turning to page 2 of the report, do you agree that air filtration does not reduce the risk of HIV transmission?

A: Air filtration does not reduce the risk HIV transmission, that's correct.

Q: And do you agree that the use of ultraviolet lights -

A: Let me, please, under the current state of knowledge, because in all fairness, the concept of aerosol spread has been repeatedly raised. It has not been put to bed. And I cited for you the Morbidity and Mortality Weekly Report of only a few weeks ago that said one should treat hemorrhagic fever as if it could be spread, namely, the Ebola virus, as if it could be spread by aerosol transmission, even though there's no evidence for it. So, I would say yes, air filtration under current knowledge will not be meaningful, with the cavea: that that is still under a state of discovery.

Q: Do you agree that the use of ultraviolet

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lights would not reduce the risk of HIV transmission?

A: Ultraviolet lights are germicidal, and it would be predicated on what I just said. It's advocated against TB. It is not a known method of dealing with HIV.

Q: Do you agree that using negative pressure would not reduce the risk of HIV transmission?

A: Yes, with the same disclaimer about if aerosols ever come to light.

Q: Based on the best current scientific knowledge, the use of negative pressure would not reduce the risk of HIV transmission, correct?

A: Yes.

Q: And based on the best current scientific knowledge, the use of respirators would not reduce the risk of HIV transmission, correct?

A: Yes.

Q: And the use of a sterile water supply would not reduce the risk of HIV transmission, right?

A: I don't know, but probably not.

Q: And the use of hair coverings would not reduce the risk of HIV transmission, would it?

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A: It would not, in my opinion.
Q: Would the use of a face shield to protect skin areas not protected by masks and safety glasses from droplet and splashes reduce the risk of HIV transmission?
A: Yes, it would.
Q: Could a face shield be used by a dentist in a dental office?
A: Could a face shield, yes.
Q: Would double gloving reduce the risk of HIV transmission ?
A: Yes.
Q: Could double gloving be done by a dentist in the dental office?
A: Yes.
Q: Would the changing of the gloves every 30 minutes reduce the risk of HIV transmission?
A: Yes.
Q: Could that procedure be done in a dental office?
A: Yes.
Q: Do you believe the treatment - let me refer you to Item X on page 2 of Deposition Exhibit 1. Do you believe that procedure would reduce the

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risk of HIV transmission?
A: "Treatment should be carefully planned." Is that what you're reading?
Q: Yes.
A: Would you kindly repeat that? I didn't understand your question.
Q: Would following the procedure set forth in Roman Numeral X on page 2 of Bragdon's report reduce the risk of HIV transmission.
A: Yes, it would.
Q: Could it be done in a dental office?
A: Yes, it can.
Q: Would the use if disposables reduce the risk of HIV transmission?

A: Yes.
Q: Could it be done in a dental office?
A: Yes.
Q: Would the covering of shoes reduce the risk of HIV transmission?
A: Possibly.
Q: How so.
A: If there were a great exposure of blood or bodily fluids through nicking of an artery, let's say, and there was a genuine splattering of

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blood, it is conceivable that just as much as hands can be contaminated with blood, hands have lesions on them. So you're shielding the shoes of a foot that have lesions on them and could be contaminated with HIV, and that's the reason for the covering of shoes.
Q: So the blood from a dental procedure would flow into the dentist's shoes, go through the shoe and the sock to a cut in the foot and transmit HIV?
A: That's a theory.
Q: Any documented evidence that that has ever happened?
A: No.
Q: Could shoes be covered in a dental office?
A: Yes.
Q: Would the use of hospital scrubs reduce the risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would the changing of the hospital scrubs after the procedure has been completed reduce the

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risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would placing the hospital scrub in an appropriate container or hamper after the procedure has been

completed reduce the risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would the use of a second assistant in a dental procedure reduce the risk of HIV transmission?
A: Yes.
Q: How so?
A: There's less exchange of instruments between the dentist; and the less chance for human error, the better off the operator is. In operating theaters - and that's one of the reasons for going into a hospital setting - you do have a second assistant for that very purpose. Place yourself in the operating room - I don't know if you've had the privilege of being in one - but

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there's a delegation of authority that is not present in an - I don't want to demean the office of Dr. Bragdon - but ...

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... is a different report (Exhibit 10 is marked for identification.)
Q: Let me show you what I marked as Kuvin Deposition 10, which is a supplemental report of Dr. Molinari.
A: I have never received this particular report.
Q: Let me show you Exhibit 10 and ask you if you've seen that report.

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A: Yes. This is the report that I have received. I'll be happy to read this if you wish, but I have not received this report.
Q: Why don't we return to the question you were answering before it occurred to you that you hadn't seen Exhibit 9 before. You were explaining what your HIV transmissions discussions were about with Dr.

Molinari?
A: Yes. That was a panel discussion meeting in New Jersey. I don't remember where. It may have been New Brunswick. I can't really recollect. And amongst the panelists were Dr. Molinari and Dr. Cottone. Dr. Cottone. as you know, is a coauthor with Dr. Molinari of books on infection control in dentistry. And Dr. Molinari, who is a Ph.D., was articulating the Kimberly Bergalis case and his perception of it at the time when that case was being hotly debated as to its authenticity, namely, did it really occur.
Because most dentists disbelieved it. Most dentists had what I would call and I said so, disregard for medical facts, disbelief of the case. And the discussion - I was not part of the panel, but I certainly asked questions from the

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floor. Dr. Molinari presented a rather correct overview of HIV, if I remember correctly. And I do remember this, however, that Dr. Cottone spoke and -
MR. McCARTHY: Do you remember the question?
THE WITNESS: Yes. It was how do you think this occurred. How do you think the transmission occurred?
A: At which point Dr. Cottone -
MR. McCARTHY: I'm talking about the question that the lawyer asked you. Do you remember the question that he asked you?
THE WITNESS: About Dr. Molinari, what did he say at the meeting, is that correct, at the meeting. Would you repeat the question then?
Q: What did Dr. Cottone say at the meeting that you can recall?
A: Dr. Cottone said that he felt the Kimberly Bergalis case was a myth.
Q: Did Dr. Molinari say the same thing?
A: No.
Q: Anything else of note that Dr. Molinari said during that meeting?

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A: Dr. Molinari didn't deny it either. He didn't disagree with Dr. Cottone.
Q: There is a theory that the dentist intentionally transmitted HIV in that case, correct?
A: There was a theory proposed.
Q: And that has not been able to be ruled out, correct?
A: I would say it has been ruled out, yes.
Q: By the CDC?
A: By the CDC.
Q: The CDC had a theory that because he was suffering from significant symptoms of HIV, that his poor health may have resulted in the transmission of HIV. Are you aware of that theory.
A: No, I'm not aware of that theory.
Q: What is your impression of Dr. Molinari as an expert on HIV transmission?
A: I think he's a well-respected expert on infection control and HIV and other infectious diseases.
Q: Do you have any reason to question his opinion on the transmission of HIV?

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A: I think he's both credible and reliable. I have some disagreements with him as to his perceptions of the transmission of HIV.
Q: What are those disagreements?
A: Well, the disagreements are centered about the risk involved, the significant risk involved in the transmission in the health care setting.
Q: Do you disagree on the quantity of the risk with Dr. Molinari?
A: Yes.
Q: What do you think the quantity of the risk is?
A: I believe that that risk is small but real. Dr. Molinari, in my opinion, believes it's infinitesimal and remote. I can't speak for Dr. Molinari, obviously. He should say that for himself, if he believes that.
Q: What do you mean by "small"?
A: Well, "small" means that 42 health care workers have

gotten HIV. And for those 42 and the 92 others, that's 100 percent. To the individual, that's 100 percent. The tragedy is 100 percent. To Kimberly Bergalis and the other five patients,

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that was 100 percent. But the numbers are small. What's most disturbing is that 60 percent of the HIV-infected people in American today don't know they're infected.
Q: How many?
A: 60 percent.
Q: Haven't you previously said 90 percent?
A: I don't believe I said 90 percent.
Q: Gold's report, didn't you say 90 percent of HIV person's are unaware of their condition?
A: That was then, and this is now. The more recent estimate by the CDC, in all fairness, in May of 1995 as articulated by Dr. Lee before the Congress during hearings conducted in May, and I'm perfectly content with his figures, is 60 percent.
Q: So 60 percent of the HIV-positive persons in this country are unaware of their condition?
A: Yes.
Q: So if they're asked by their dentist if they were HIV positive, they would say, "I'm not"?
A: They would say "I'm not" or "I don't know," one of the two. They wouldn't say "I'm not" because they weren't tested.
Q: So your conclusion that the risk is small

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is based on the assumption that one transmission of HIV would be significant?
A: It's based on more than that. It's based on the mathematical formulas put forward by the CDC which said back in 1991 that an infected health care worker, an invasive health care worker's chance of transmitting HIV to a patient over a seven-year period would be anywhere from 2 to 8 point something percent with a

high of 12 percent if you're in a highly invasive specialty like orthopedics or what have you.
Those figures have been bantered around and contested and debated anywhere from 1 to 40,000, 400,000 procedures. The fact is that the risk is small, no matter what numbers you care to use. But they're real. They're not infinitesimal. They're not remote, and they're not nonexistent.

Q: The statistics you referring to from the CDC is concerning the risk of transmission from the health care provider to the patient, correct?

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...

A: I agree with the second sentence.
Q: Do you agree with the third sentence?
A: I disagree with the third sentence.
Q: Do you agree with the fourth sentence?
A: I disagree with the completeness of the fourth sentence or the incompleteness, I should say, of the fourth sentence.
Q: Do you agree with the fifth sentence?
A: I agree with the fifth sentence.
Q: Do you agree with the last sentence of Paragraph 18?
A: I agree with the last sentence.
Q: Have you reviewed the materials cited in this report on pages 3, 4 and 5?
A: I've reviewed many of these, yes. I cannot state with certainty that I reviewed all of them. But many of them look familiar to me.
Q: Can you indicate what you believe are reliable authorities on HIV transmission, to the extent you're able to render such an opinion.
A: No. 1. No. 2.
Q: These are all reliable authorities on HIV

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transmission?
A: The reliable authorities are No. 1, No. 2, No. 4, No. 5,

No. 7, No. 8, No. 9, No. 10, No. 11, No. 12, No. 13, No. 14, No. 16, No. 17, No. 18, No. 19 (Exhibit 11 marked for identification.)

Q: Let me show you what I've marked as Kuvin Deposition Exhibit No. 11, which is Dr. Craven's report. Are you familiar with Dr. Craven?
A: Only by the material presented to me.
Q: Are you familiar with his reputation as a reliable authority?
A: No.
Q: Have you ever had any personal contact with him?
A: No.
Q: You have reviewed Dr. Craven's report to prepare for today's deposition?
A: I have.
Q: And you reviewed his credentials?
A: I have.
Q: Do his credentials appear to qualify him as an expert on infection control and HIV transmission?

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A: They certainly do.
Q: Do you have any reason to question his credibility and reliability as an expert in this case?
A: Not at all.
Q: Let me ask you to look at what I've marked - let me ask you one more question about your review of Dr. Craven's credentials. Do they appear to qualify him as an expert on the transmission of TB?
A: Yes.
Q: Let me show you what I've marked as Kuvin Deposition Exhibit 12, the report of Dr. Marianos.
A: Right.
Q: You've read that before today's deposition.
A: Yes, I have.
Q: Are you familiar with him?
A: I know of Dr. Marianos.
Q: Do you consider him to be an expert on HIV transmission?
A: Dr. Marianos, to the best of my recollection, is an officer of the public health service in the CDC as a

dentist and has worked in

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research in the dental unit and certainly would be regarded as an expert in HIV.

Q: And on the proper management of dental patients with HIV?

A: I regard him as an expert in his opinion. I don't agree with Dr. Marianos. But, yes, I do regard him as an expert.

Q: And Dr. Craven's credentials appear to qualify him as an expert on the management of patients with TB?

A: They certainly do.

Q: Do you have any reason to question the reliability or credibility of Dr. Marianos as an expert in this case?

A: Not at all.

Q: Do you agree that Dr. Marianos is more familiar with the CDC statistics on the 42 transmissions of HIV to health care workers than you are?

A: Yes.

Q: So you would defer to him on the precise facts of those transmissions?

A: I think that's reasonable, yes.

Q: Based on your review of Dr. Marianos'

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report, what are your points of disagreement with him?

A: You would have to take this down from the top.

Q: Okay, you go through the report -

A: Yes.

Q: - and tell me what you disagree with line by line.

A: On page 4, No. 5, Dr. Marianos states, and I quote, "In 1993 the CDC issued revised recommended infection control practices for dentistry. The 1993 document updates previously published CDC recommendations for infection control."

Q: Instead of reading, could you just tell me when you disagree.

A: Yes. In that 1993 document, the 1993 document articulates the dangers of spread of infectious agents.

And it lists them as cytomegalovirus, streptococci, staphylococci, CMV, HIV, hepatitis B by saliva, by blood, and other methods including droplet infection. And none of this is articulated in Dr. Marianos' description of the 1993 document.

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No. 6, Dr. Marianos says, "No infection control procedures beyond the use of universal precautions are necessary in providing routine dental care to persons with HIV and AIDS." For the sake of brevity, I think we've covered my objections to that statement, namely, that universal precautions do not provide for universal safety. We've spent a reasonable amount of time, unless you want me to go over it again I will, as to why I feel so strongly about that and where universal precautions break down. And, secondly, universal precautions, of course, do not provide for the problems associated with HIV which are absolutely part and parcel of the epidemic and in fact are part of the locomotive driving it.

So I disagree with Dr. Marianos' statement that no infection control procedures beyond the use of universal precautions are necessary in providing routine dental care to persons with HIV and AIDS. If you want further amplification, fine. I'll discuss it with you.

Q: What other precautions do you think should be taken?

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A: I think that patients with HIV/AIDS have to be judgmentally observed by the treating dentist and that patient determined by the good judgment of the health care worker as to what facility, what special facility if necessary, is obligatory for the further safety of the patient, the health care worker, the health care worker's associates and the time and attention that can be given to that patient outside of a dental operatory.

Q: So you believe that the dentist should make an individualized assessment of each HIV-positive patient

to determine what precautions if any are necessary beyond universal precautions?

A: Yes.

Q: And sometimes, based on that individualized assessment, the dentist will determine that additional precautions are needed beyond the universal precautions?

A: Yes.

Q: And sometimes, based on that individualized assessment, the dentist will determine that no additional precautions are necessary beyond the universal precautions to provide routine dental care?

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A: That is also correct.

Q: How about the second sentence of Paragraph 6? Do you agree with that?

A: I disagree with that in that it's an error, in my opinion an error of omission. It's not, the CDC does not go on to articulate the use of infection control procedures except for the fact that in 1995, or I should say in 1994, they have gone beyond this in terms of the referral of patients who are suspected of having TB for further evaluation. And, again, Dr. Marianos makes no reference to that.

Q: What's the cite to the CDC publication that you're referring to ...

A: Dr. Marianos is one of the authors on it. And that's the CDC recommendations in 1994 for tuberculosis control in dentistry, and Dr. Marianos is the sixth author on that publication.

Q: Is that the authority that you're relying on with regard to how dentists should handle the risks of TB when dealing with patients?

A: It's one of the authoritative sources, yes. Would you like me to.

Q: If you've finished expressing your

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disagreement with Paragraph 6, I'd ask you to move on

to Paragraph 7.

A: I disagree with Paragraph 7.

Q: Do you disagree because sometimes you think that additional precautions are necessary?

A: Yes. And that should be the individual judgment of the health care practitioner.

Q: Based on an individualized assessment of the particular patient they're treating?

A: Exactly.

Q: If we've exhausted your disagreement with Paragraph 7, we can move on to Paragraph 8.

A: I wouldn't say you've exhausted it, but we can move on.

Q: No, I want you to have an opportunity to fully express your disagreement. So if you have any other reasons for disagreeing with Paragraph 7, go ahead.

A: Well, let me just say this. Throughout the world it has been recognized since infection control has come under scrutiny that there are specialized centers that are required from time to time. And, for example, I personally have worked at fever hospitals, I've worked at infectious

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disease hospitals that segregate patients. Why? Because they come under better scrutiny, more precautions and greater observation, something that you can't put into a statute or a law.

Namely, by their very presence in that facility, they are handled in a better and a better judgmental way with the comfort and the confidence of the staff involved. If you're at an institution, whether it be the NIH where I used to work, we treated patients differently when they came on the infectious disease floor. When I was a full-time assistant professor at the University of Miami, we treated patients differently when they came under our aegis and medical care, because they required special attention.

If we were dealing with patients by the clock and by appointment, as it were, we would be doing them and us a terrible disservice. So the concept of centralized

care, or special care, I should say, has been an established fact, whether it is in infectious diseases or whether it's in heart disease or in breast cancer or whatever it may be. That concept of medicine is not unique, except in the field of HIV.

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Q: Are you aware of any specialty in dentistry for persons treating HIV patients?

A: No. And that's the rub, that dentistry has been remiss in creating a specialty in infectious diseases. They have no specialized training. OSHA requires Dr. Bragdon to supervise his employees. Well, his employees are not recertified in anything in infection and disease control
They're certified, for example, in CPR but not in infectious disease control. Therefore, how can Dr. Bragdon practice good dentistry if he himself is not required by dental purview to be an expert, which he can't because there is no specialty of infectious diseases in all the specialties of dentistry.

Q: Are you aware of any specialized facilities in Maine that provide routine dental services to HIV-positive patients?

A: No, I'm not.

Q: Is it your understanding that Dr. Bragdon referred the plaintiff in this case to a specialized center for the treatment of HIV

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patients with dental needs?

A: My only information in that regard - you'll have to excuse my lack of knowledge - is through Dr. Bragdon's deposition. And I remember a hospital where he attempted to get privileges at, but it was a very short discourse as to the availability of specialized centers. I know that Dr. Bragdon has attempted to create such a specialized center unsuccessfully, but that's all I know.

Q: Did he volunteer to serve at that facility, as far as you

know?

A: I don't know that.

Q: Any other points of disagreement you have with respect to Paragraph 7?

A: I think I've just articulated my objections to Paragraph 7.

Q: I just wanted to make sure you had a full opportunity. What are your areas of disagreement with Paragraph 8?

A: I strongly disagree with Paragraph 8 for the reasons I just articulated about Paragraph 7. That a general dentist by training, by experience, by certification, by recertification and by the

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ever changing kaleidoscope of change in HIV and associated opportunistic infections, in fact in emerging diseases, is not qualified to deal with this onus of responsibility.

Q: Do you think a general dentist lacks the expertise necessary to treat patients with hepatitis B?

A: Again, that's a rather difficult judgment call without knowing the condition of the patient. If the patient with hepatitis B, for example, has cancer of the liver, then that's one story. If the patient is totally asymptomatic and had hepatitis B and recovered, that's another story. If the patient is E antigen positive as a chronic carrier, that is still a third story that carries a difference - again, I really don't want to be , I hope you don't construe me as being argumentative. I'm trying to say to you that it requires medical judgment.

Q: Medical judgment including an individualized assessment of the particular patient that the dentist …

***

RANDON BRAGDON, D.M.D. INFECTIOUS DISEASE POLICY

Patients will not be treated in the office who are known to be infectious and/or contagious with a disease that is life threatning (sic) or may cause long term or permanent debility. This includes but is not limited to strep throat, hepatitis A,B,C and non A-B, HIV+/AIDS, TB, measles etc.

Patients will be treated when their attending physician determines that the patient is no longer infectious and/or contagious.

Patients of record who require emergency dental treatment and are infectious and/or contagious as specified above will be referred to an appropriate treatment setting.

This policy has been in effect since September 18, 1978.

EXCERPTED FROM THE AMERICAN DENTAL ASSOCIATION POLICY ON AIDS, HIV INFECTION AND THE PRACTICE OF DENTISTRY

PROFESSIONAL CONSIDERATIONS

The Association believes that HIV-infected individuals should be treated with compassion and dignity. Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.

A sound approach to the treatment of infectious patients requires an assessment of the patient's condition based on reasonable and informed medical judgments, given the state of medical knowledge at the time. A dentist should not refuse to treat a patient whose condition is within the dentist's current realm of competence solely because the patient is HIV infected.

Dentists should be alert to signs and symptoms of HIV infection that may be identified during the provision of dental care. Patients with histories or conditions possibly indicative of HIV infection should be referred to their physicians for diagnostic procedures, counseling and medical follow-up.

The Association believes that all HIV-infected patients should disclose their HIV status and medical history: dentists, like physicians, need to know every patient's medical history in order to make appropriate treatment decisions that are in the best interest of the patient. For the same reason, the Association also strongly supports state and federal legislation that gives an HIV-infected patient's health care providers the right to share knowledge of the patient's HIV status and current medical condition without risking a violation of state or federal antidiscrimination laws and HIV confidentiality laws. The Association further strongly supports state and federal legislation that protects a dentist from charges of discrimination

if a dentist in a sincere effort to protect a patient's health, elects to refrain from treating a patient who fails to disclose his/her HIV status and medical history or allow an HIV test to be performed.

The Association urges dentists to maintain strict confidentiality of the patient's HIV status and medical condition, except as noted above with respect to sharing of information among the patient's health care providers when allowed by state or federal law. Dentists are encouraged to have an office protocol for the confidential handling of information about an HIV-infected patient.

The Association believes that individuals with HIV infection should have access to dental treatment. Treatment considerations should provide for a judicious balance between the well-being of these patients and the protection of the health of the public as well as the dental care providers.

AMERICAN DENTAL ASSOCIATION

ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT
(With official advisory opinions revised to January, 1995)

The ethical statements which have historically been subscribed to by the dental profession have had the benefit of the patient as their primary goal. Recognition of this goal, and of the education and training of a dentist, has resulted in society affording to the profession the privilege and obligation of self-government. The Association calls upon members of the profession to be caring and fair in their contact with patients. Although the structure of society may change, the overriding obligation of the dentist will always remain the duty to provide quality care in a competent and timely manner. All members must protect and preserve the high standards of oral health care provided to the public by the profession. They must strive to improve the care delivered - through education, training, research and, most of all, adhere to a stringent code of ethics, structured to meet the needs of the patient.

Principle - Section 1

SERVICE TO THE PUBLIC AND QUALITY OF CARE

The dentist's primary professional obligation shall be service to the public. The competent and timely delivery of quality care within the bounds of the clinical circumstances presented by the patient, with due consideration being given to the needs and desires of the patient, shall be the most important aspect of that obligation.

Code of Professional Conduct

1-A PATIENT SELECTION

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex, or national origin.

Advisory Opinion

1. A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

1-B. PATIENT RECORDS

Dentists are obligated to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon requests of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient.

Advisory Opinions

1. A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental x-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full.

2. The dominant theme in Code Section 1-B is the protection of the confidentiality of a patient's records. The statement in this section that relevant information in the records should be released to another dental practitioner assumes that the dentist requesting the information is the patient's present dentist. The former dentist should be free to provide the present dentist with relevant information from the patient's records. This may often

be required for the protection of both the patient and the present dentist. There may be circumstances where the former dentist has an ethical obligation to inform the present dentist of certain facts. Dentists should be aware, however, that the laws of the various jurisdictions in the United States are not uniform, and some confidentiality laws appear to prohibit the transfer of pertinent information, such as HIV seropositivity. Absent certain knowledge that the laws of the dentist's jurisdiction permit the forwarding of this information a dentist should obtain the patient's written permission before forwarding health records which contain information of a sensitive nature, such as HIV seropositivity, chemical dependency or sexual preference. If it is necessary for a treating dentist to consult with another dentist or physician with respect to the patient and the circumstances do not permit the patient to remain anonymous, the treating dentist should seek the permission of the patient prior to the release of data from the patient's records to the consulting practitioner. If the patient refuses, the treating dentist should then contemplate obtaining legal advice regarding the termination of the dentist patient relationship.

1-C COMMUNITY SERVICE

Since dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

Advisory Opinion

1. A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.

1-D. EMERGENCY SERVICE

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record.

Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, ...

19.

[Randon Bragdon, D.M.D.
letterhead]

November 7, 1994

Office of the Administrator,
George Avery
Down East Community Hospital
RR1, Box 11
Machias, ME 04654

Dear Mr. Avery,

Please find enclosed my application for courtesy privileges status.

Sincerely, s/Randon Bragdon,
D.M.D.

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Check third column for requested privileges REQ

RANDON BRAGDON, DMD
DOWN EAST COMMUNITY HOSPITAL
RR1 Box 11, Machias, Maine 04654

Today's Date: 11/1/94

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

National Data Bank Requires Date of Birth: 05/02/45

Identifying Information

Last Name: Bragdon | First Name: Randon | Initial: E | Social Security No.: 005-46-6718

Residence Address:
129 Hudson Road, Bangor, Maine 04401
Telephone: (207) 942-5976

Other Address:
30 Judson Boulevard, Bangor, Maine 04401
Telephone: (207) 947-0284

Citizenship: USA | E.C.F.M.G. No/Date Issued: N/A

Medicare No. 005-46-6718

Premedical Education

College or University	Degree	Honors
University of Maine	B.A. Physics	High

Street	City	State	Zip	Date of Graduation
	Orono	Maine	04473	6-1-67

Medical Education

Medical School	Degree	Honors
Tufts School of Dental Medicine	D.M.D.	Class V.P.

Street	City	State	Zip
136 Harrison Ave.,	Boston,	Mass	02111

Date of Graduation: 6-16-78

Internship

Hospital (Full Name)
Togus Veterans Hospital

Street	City	State	Zip
VAMROC	Togus	Maine	04330

Dates
April-May 1978

Type of Internship	Specialty
Dentistry	General

Practitioners Responsible for Performance (Chief of Staff, Chairman of Departments, Others)
Dr. James Schmidt, Dental Chief (207) 623-8411

Residences, Fellowships, Preceptorships, Teaching Appointments

Facility (Full Name)
University of Maine Dental Health Programs and Clinic

Street	City	State	Zip
Lincoln Hall	Bangor	Maine	04401

Dates
1979-Present

Type
Clinic and In-Office Training

Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept. etc.)
Dawn Bearer RDH, Med.

Continuing Medical Education

(blank)

Affiliations

Present Capacity with this Hospital
Consultant and Provider Dental Services

Dates 1974-Present

Facility (Full Name)
Bangor Mental Health Institute

No. of Beds: 1200-265 Present

Street	City	State	Zip
State Street	Bangor	Maine	04401

Dates: 1979-present

Membership in Professional Societies

Are you a member of the Penobscot County Dental Association? Yes.

Do you have an application pending? No

Do you intend to apply? (blank)

If you are a present member of, or applicant to, other County, State of National Society, list names and status below.

American Dental Association, Maine Dental Association, Penobscot Valley Dental Society, Academy of General Dentistry, American Ortho Society Internation Association of Orthodontics, International Dental Health Foundation

Fellowship	(blank)
Certification	(blank)
Licensing	Medical License (Name of State and County) Maine Board of Dental Examiners Date Issued Date Expires License No. 7-1-78 12-31-95 27? Drug Enforcement Administration Renewal Date 7-31-96 License No. AB8261985
Liability Insurance	Amount of Coverage Insurance Carrier 2,000,000/3,000,000 CNA Expiration Date: 11-30-9? Policy No. (blank) Agent (Name and Full Address) Morse, Payson & Noyes Insurance, 100 Middle St., P.O. Box 406, Portland, ME 04112 Prior Carrier: St. Paul During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes. Have you ever been denied Professional Liability Insurance? No.
Disciplinary Actions	Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

Medical License in any state	No
Other professional registration/license	No
DEA registration	No
Academic appointment	No
Membership on any hospital medical staff	No
Clinical privileges	No
Prerogatives/rights on any medical staff	No
Other institutional affiliation or status thereat	
Professional society membership or fellowship/ Board certification	No
Professional office	No
Any other type of professional sanction	No
Have there been any felony criminal charges brought against you in the last 5 years?	No

Description of current practice	Practice Limited to General Dentistry Practicing With Whom and Nature of Affiliation Solo Practitioner

Health Status	Date of Most Recent Physical Exam 4-91 Performed by Location Paul Revere Ins. Office Significant Findings: None Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? No. Are you currently engaged in any rehabilitation program? No.
Medical References	Dr. Charles H. Dorr, P.O. Box 373, Machias, Me 04654 Tel: (207) 255-3352 Dr. William C. Caddoo, 175 Water St., Bangor, Me 04401 Tel: (207) 667-5744 Dr. William J. Deighan, 37 Bower St., Bangor, ME 04401 Tel: (207) 945-5691
Member-ship appoint-ment and privileges desired	Special Procedures (specify) General Dentistry Privileges Desired: Dental **Delineation of Medical Privileges Desired** [blank] **Delineation of Anesthetic Privileges Desired** [blank] **Delineation of Surgical Privileges Desired** [blank] **Continuation of Delineation of Surgical Privileges Desired** [blank] **Special Surgical Procedures - provide supporting documentation** [blank] **Delineation of Gynecological Privileges Desired** [blank] **Delineation of Obstetrical Privileges Desired** [blank] **Delineation of Pediatric Privileges Desired** [blank] **Continuation of Delineation of Pediatric Privileges Desired** [blank] **Delineation of Radiological Procedures** [blank]

Delineation of Orthopedic Privileges Desired
[blank]
Continuation of Delineation of Orthopedic Privileges Desired
[blank]
Delineation of Dental (maxillofacial/oral surgery) Privileges Desired
Rehabilitation of Dental Arches
Operative restorative
Crown and bridge preparation
Prosthetic replacement of teeth
Implantation of teeth
Oral Prothesis
Congenital
Traumatic
Extractions
Single, uncomplicated
Multiple, uncomplicated
Surgical removal, impacted
Intra-Oral Surgery
Root Resections
Alveoplasty
Toris mandibularis
Simple intra-oral biopsy
Lacerations
Tumors
Cysts
Infections
Appointment Recommended
Appointment Not Recommended
Appointment Deferred
Comments
[blank]

Attachment for Answer to the Question:

"During the past ten years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?"

In sixteen years of practice there has been only one malpractice suit. On December 1, 1984 I raised a flap on the wrong side in preparation to remove an impacted maxillary third molar. I had gone over the panographic x-ray several weeks before with the label properly placed and orienting the radiograph correctly. Sometime in the interim, my receptionist reversed the label for reasons known only to herself. The result was that the radiograph was reversed when used for reference during the extraction. That patient was informed immediately, the flap replaced, and the flap raised on the other side and the impacted third molar extracted. The receptionist was fired a few weeks later for not following instructions, office policies and procedures, altering records and forging my signature. It is my belief that the receptionist incited the patient to sue. St. Paul settled the suit for $1,400.00.

There is a suit pending with the Maine Human Rights Commission (MHRC) and Gay Lesbian Advocates and Defenders (GLAD) of Boston. This suit is in regards to my long standing infectious disease policy.

CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
Washington, D.C. 20537

DEA Registration Number	Expires	This Registration Fee Paid	
AB8261985		07-31-96	$210.00

Schedules	Business Activity	Date Issued
2,2N,3,3N,4,5	Practitioner	07-

Bragdon, Randon Elvin DMD
30 Judson Blvd
Bangor, ME 04401

No. 000541

STATE OF MAINE
BOARD OF DENTAL EXAMINERS
1994-1995
REGISTRATION

This is to certify that the dentist named below has duly registered to practice dentistry for the biennial period 1994 - 1995 in accordance with Title 32, Maine Revised Statutes, 1990 Chapter 16, as amended.

Randon E. Bragdon, DMD 2732
30 Judson Blvd
Bangor ME 04401

s/Ross G. Wyman, D.D.S.
Secretary, Board of Dental Examiners

Void unless validated with
Seal of the Board

EXPIRES, DECEMBER 31, 1995 DISPLAY WITH LICENSE

Board of Dental Examiners
State House Station #143, Augusta, ME 04333
Tel: (207) 287-3333

Name: Randon Bragdon
Address: 30 Judson Blvd
Bangor, Maine 04401

Log of Continuing Education Activities for the Period
January 1, 1994 to December 31, 1995 Maine Dental Lic#2732

Category 1: CDE Activities with accredited sponsorship
At least 30 credits must be earned in this category.
The total - 40 - may be earned in this category

I certify the following to be true and correct for the period January 1, 1994 to December 31, 1995. This form must be completed, signed and returned with your completed reregistration application.

Accredited Sponsor	Location of Activity City, State	Description of Activity	Dates of Attendance	Credits
Mass Dental Soc.	Boston, MA	A.I.D.S. Panel	1-20-94	3
"	"	Arin Identifications/ Haber	1-20-94	3
"	"	Oral Lesions/ Santis	1-21-94	3
"	"	Current Concepts/Lurie	1-21-94	3
"	"	Porcelains Laminates/ Panel	1-22-94	5
"	"	Complete Dentures/ Hammer	1-22-94	3
Maine Dental Assoc.	Augusta, ME	LEAD Ledgis, Edu Awareness/ Police	2-5-94	4
American Ortho Soc.	Charlotte, No. Carolina	Straight Wire Update/Gerety	4-22-94	16
Amer. Dental Assoc.	Chicago, IL	Peers Network	9-30-94	8
Amer. Dental Assoc.	Chicago, IL	HIV, Disease Considerations for Dentistry 94	10-1-2-94	10 58 credits
Phys Res. Council of Mass	Newton, Mass	Sexuality Education and STD's of the 90's	9-17-94	6

Family Institute				

Board of Dental Examiners
State House Station #143, Augusta, ME 04333
Tel: (207) 287-3333

Name: Randon Bragdon
Address: 30 Judson Blvd
Bangor, Maine 04401

Log of Continuing Education Activities for the Period
January 1, 1992 to December 31, 1993 Maine Dental Lic#2732

Category 1: CDE Activities with accredited sponsorship
At least 30 credits for Dentists (15 for Hygienists) must be earned in this category. The total - 40 for Dentists and 20 for Hygienists - may be earned in this category.

I certify the following to be true and correct for the period January 1, 1992 to December 31, 1993. This form must be completed, signed and returned with your completed reregistration application.

Accredited Sponsor	Location of Activity City, State	Description of Activity	Dates of Attendance	Credits
AGD - Massachusetts	Boston, Mass	Infection Control	1-23-92	5
"	"	Endodontics	1-24-92	3
"	"	Endodontics	1-24-92	3
"	"	Medical Emergencies	1-25-92	3
"	"	Infection Control	1-25-92	3
ME Dental	Togus, ME	Oral Diagnosis for the G.P.	2-7-92	6
ADCO	Bangor, ME	Infection Control	3-25-92	4
MDA	Samoset, ME	General Attendance	6-19-92	5
MDA	"	OSHA Update	6-19-92	3
MDA	Samoset, ME	Oral Lesions in Patients w/HIV infection	6-20-92	1.5
MDA	Portland, ME	Risk Management	4-2-93	5
Tufts Univ	Boston, MA	Future of Dentistry	5-1-93	2
Me. Dental Assoc.	Samoset, ME	Is it ___ or is it Resin-Composite	6-20-92	1.5

Me. Dental Assoc.	Togus, ME	Pharmicology - Sam Holoyd	11-19-93	6
Penob. Medical Assoc.	Bangor, ME	Maine-Universal Health Care Plan	11-18-93	1

Account Number
0004811001

NOTICE

Your professional liability insurance is written on a "claims made" basis and provides coverage for those claims which are the result of dental incidents occurring subsequent to the prior acts date stated below and which are first made against you while this insurance is in force. Please discuss with your agent.

Policy Number From Policy Period To
DLP 0481-10-01 11/30/93 11/30/94
Coverage is Provided by: Continental Casualty Co.
Named insured and Address: National Administrator
Randon Bragdon, DMD Poe & Brown, Inc.
30 Judson Blvd P.O. Box 3268
Bangor ME 04401 Tampa, FL 33801-3268
State Administrator Number:
970-039717

Limits of Insurance		**Coverage**
$2,000,000 Each Claim		Professional Liability - Claims-Made
$3,000,000 Aggregate		
$2,000,000 Each Occurrence		General Liability - Occurrence
$2,000,000 Aggregate		Products Hazard/Completed Operations Hazard - Occurrence
$0	Each Claim	ERISA Fiduciary Liability - Claims Made

$2,725.00 Policy Premium
Printed Endorsements Attached at Policy Issuance:
G-15158-A, G-15159-A, G-15160-A, G-17739-A, G-18479-A, G-19092-A, G-19093-A, G-41500-O, G11715318, G15175A18, G16856899, C90182001.

S/Corporate Secretary
Chairman of the Board
Countersigned by/Authorized Representative
G-15155A (ED 7/91) Issue Date: 10/12/93

MORSE, PAYSON & NOYES
INSURANCE

October 5, 1994

Randon Bragdon, D.M.D.
30 Judson Boulevard
Bangor, ME 04401

Dear Dr. Bragdon:

Your Professional Protector Plan policy will be expiring on 11/30/94.

As part of the renewal process, attached is a Summary of Insurance to provide you a summary of your current coverages. Please review this summary and advise us of the renewal instructions per the attached "You Tell Us" Form.

The professional liability application is also attached. Since the premium and coverage are based on the information provided in the application, it is necessary for you to complete and return it to us.

Also attached is our invoice for the estimated renewal premium based on last year's premium. Once this year's actual renewal premium has been determined, a final adjustment will be done. Because the insurance company holds us responsible for the premium as of the effective date of coverage, payment needs to be received 10 days prior to the renewal date in order to avoid non-renewal of your policy by the insurance company.

Please return the completed renewal application and your selection form in the enclosed envelope within the next two weeks.

Sincerely,
S/Leta L. Bryant, Customer Service Representative

APPLICANT'S ACKNOWLEDGMENT

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making his application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the by-laws, rules and regulations of the medical staff of this hospital, and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others (including past and present malpractice carriers) who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I further hereby release from liability any and all individuals and organizations who provide information to the hospital or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this

hospital or its medical staff to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and to resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Date: November 7, 1994 S/Randon Bragdon, D.M.D.

Exhibit 1

Randon Bragdon, D.M.D.
30 Judson Boulevard
Bangor, Maine 04401
Telephone: 947-0284

Infectious Disease Policy

Patients will not be treated in the office who are known to be infectious and/or contagious when a disease that is life threatening or may cause long term or permanent debility. This includes but is not limited to strep throat, hepatitis A, B, C and non A-B, HIV-/AIDS, TB, measles, etc.

Patients will be treated when their attending physician determines that the patient is no longer infectious and/or contagious.

Patients of record who require emergency dental treatment and are infectious and/or contagious as specified above will be referred to an appropriate treatment setting.

This policy has been in effect since September 18, 1978.

[Down East Community Hospital letterhead]

[Letter to Dr. Bragdon from Down East Hospital dated 03/31/95]

Good Morning Dr. Bragdon:

In order to further process your application for appointment to the Medical Staff of our Hospital, we are seeking some additional information, as follows:

1. Please provide further details regarding the so-called John Doe case which has been discussed in various press accounts, including sharing with us:

A. Copies of any court pleadings;

B. Copies of any correspondence to or from the Maine Human Rights Commission;

C. Copies of any documents reflecting the disposition of the matter by the Maine Human Rights Commission;

D. Further detail from you as to how this suit relates to your "longstanding disease policy" and your planned response to this litigation.

2. Please provide further details regarding the lawsuit brought in early December in U.S. District Court by Sidney Abbott, including the following:

A. Copies of any court pleadings;

B. Copies of any correspondence to or from the Maine Human Rights Commission;

C. Copies of any documents reflecting the disposition of the matter by the Maine Human Rights Commission;

D. A further statement from you as to the nature of this litigation and your planned response.

3. Please share with us the nature of your "longstanding infectious disease policy".

4. If your policy is to refuse to treat AIDS and HIV patients in your office, how do you respond to statements in the press from a spokesman for the Mine[sic] Dental Association, Frances Miliano, that the "refusal to treat (in an office) based solely on the patient's HIV-positive status is unethical" based on policy statements from the ADA?

5. Please review the enclosed statement from the ADA regarding its view of ethical duties for dentists in terms of treating HIV positive patients in the dentists' offices and indicate whether you follow this view, and if not, why not.

6. Are you under any review by the State Board which licenses Dentists?

7. Are you still a member in good standing of the Maine Dental Association or under any review by that body?

8. Is it your intention to treat patients at our Hospital who might otherwise be treated at your or another dentist's office, and if so, is this cost-effective treatment for these patients?

9. Please provide any other detail you would care to share with this Hospital regarding your policy, these lawsuits, and the controversy surrounding the matter.

The Hospital's interest is in reviewing the nature of care you provide, or decline to provide, against applicable ethical and legal standards governing your profession. It is further interested in evaluating whether it is cost-effective to treat patients in a hospital setting who might otherwise be treated in a dentist's office.

We look forward to your response to each of the

preceding questions in order to evaluate your application. We will not deem your application complete until we have these materials.

Sincerely, /s/ George Avery, FACHE, Administrator
pc: F. James Whalen, M.D., Chairman, Credentials Committee

[Down East Community Hospital letterhead]

April 25, 1995

Randon E. Bragdon, D.M.D.
30 Judson Boulevard
Bangor, Maine 04401

Good Morning Dr. Bragdon:

It is my understanding you recently spoke with my secretary, Elin Bennett, to inquire regarding the status of your application, and to request that it be moved forward if possible.

Please understand that this Hospital shares your interest in addressing the issues raised by your pending application for limited privileges. In this regard, the Hospital must review carefully the issues raised in my letter of March 31, 1995, in light of the determination of the Maine Human Rights Commission at its February 13, 1995 meeting that there were "reasonable grounds" for finding against you with respect to compliance with the Maine Human Rights Act. One of the specific bases referenced in its investigator's report was your alleged deviation from pertinent principles of ethics and the Code of Professional Conduct of the American Dental Association.

These issues are pertinent to the Hospital's consideration, among other reasons, as a consequence of its own medical staff by-laws. Article III, Section 2(b) states in pertinent part that:

> Acceptance of membership on the medical staff shall Constitute the staff member's agreement that he will strictly abide by . . .the Code of Ethics of the American Dental Association. . . .

The Hospital is further legitimately concerned with whether your actions comply with applicable state and federal laws, and contribute to the cost effective treatment of its patients.

For the Hospital to evaluate these issues, it is essential that you provide us with responses to the questions we have raised. With this information we may be able to process your application, or we may determine that the Hospital should defer action or is not able to make determination until the Federal Court litigation is resolved. We are willing to consider the information you provide further and make such a determination at that point.

I also wish to advise that I will be leaving the Hospital's staff as of April 28, 1995. Following my departure, Lois Macias, Director of Support Services, will be handling these issues. Also, the Hospital has arranged for counsel to guide us in this matter. Should your attorney have any questions about the Hospital's position we will provide identity information.

I trust you will have a better understanding of the basis for the Hospital's position and its concerns. We look forward to addressing the issues raised by your application against this background and hope this information is helpful.

Sincerely, s/George Avery, FACHE, Administrator
p.c. F. James Whelan, M.D., Chairman Credentials Committee
Lois Macias, Director, Support Services

SEPTEMBER 1, 1995 DEPOSITION OF ROBERT VEROSLOFF, M.D.

[Caption omitted in printing]

[Page 1]

Taken before Cheryl C. Pieske, Registered Merit Reporter and Notary Public, in and for the State of Maine, on September 1, 1995, at the Down East Community Hospital, Machias, Maine, commencing at 7:45 a.m., pursuant to notice given.

Appearances:
For the Plaintiff:
(Via Telephone) Bennett H. Klein, Esq.
For the Defendant: John W. McCarthy, Esq.
For Down East
Community Hospital: Penny St. Louis, Esq.

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(The deposition of Robert Verosloff was taken at the Down East Community Hospital, Machias, Maine, on September 1, 1995. Present for the deposition in Machias, Maine, were Penny St. Louis, Esq.; John W. McCarthy, Esq.; Cheryl C. Pieske, RMR, and Randon Bragdon, D.M.D. Present via telephone were Bennett Klein, Esq. and Daniel Jackson.)

(Deponent administered oath by the reporter.)
ROBERT VEROSLOFF, being duly sworn, on his oath, deposes and says as follows:

EXAMINATION

BY MR. KLEIN: (Via telephone).

Q. Could you state your full name for the record?
A. Robert Leland Verosloff.
Q. Are you on the staff of the Down East Community Hospital?
A. Yes.
Q. And what is your position at the Down East Community Hospital?
A. Physician. Also on, I guess for this, on the board of the – the head of the infectious control.
Q. And can you tell me what your responsibilities are as the head of infectious control?

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A. Well, to oversee the meetings, to make sure the the [sic] policies are implemented and that the controls are there.
Q. Okay. And by controls, are you referring to any hospital policies for the control of infectious diseases in the hospital setting?
A. Yes.
Q. What are a of medicine do you practice in?
A. Internal medicine.
Q. How long have you been the head of infectious control at the hospital?
A. Two years.
Q. And as head of infectious control, are you familiar with the infection control methods and procedures used at

the hospital?
A. Yes.
Q. Okay. And that would include the infection control methods or procedures used in surgical operatories or other patient treatment areas?
A. That would include the whole hospital.
Q. Okay. Does any surgical operatory at Down East Community Hospital have ultraviolet lights?
A. No.
Q. Hello?
A. No.

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Q. I'm sorry. Did you hear me?
A. Yes. I said no.
Q. Oh, okay. Just because I didn't hear your answer, I just want to ask the court reporter if you could just read back the question and answer so I know that we got it because my phone was a little bit off.
(Last question and answer read by reporter.)

BY MR. KLEIN:

Q. Does any surgical operatory or is any surgical operatory at the Down East Community Hospital constructed with negative air pressure?
A. No. No.
Q. Okay. Dr. Verosloff, are there different types of operating rooms at the hospital?
MS. ST. LOUIS: Ben, what do you mean by that? Could you be more specific?
MR. KLEIN: Sure.
Q. Could you describe to me the different types of rooms that patients would be treated in for surgical procedures?
A. I don't think I could do that. I don't deal with surgery well enough to –
Q. Okay. Do you know how many different patient surgical rooms there are at the hospital?

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A. Do you mean operating rooms or do you mean rooms

on the floor for patients after the surgery?
Q. Well, let's start with operating rooms.
A.. Operating rooms, I don't know.
Q. Okay.
A. I believe that they are all the same though.
Q. Okay. And when you say all the same, are there – would those include both rooms for outpatient day surgery as well as patients who may be staying in the hospital?
A. We don't have any special facilities for outpatients.
Q. Okay. Now, with respect to the operating rooms, have you ever seen them?
A. I have been in them but just as a visitor.
Q. Not as a surgeon?
A. Not as a surgeon.
Q. Okay. And based on your observations of the operating rooms, do they have tables for the patients that are actually fixed in place?
A. Yes.
Q. Okay. So those tables where the patients lie for their surgery cannot be removed, is that correct?
A. As far as I know, yes.
Q. Are there other pieces of equipment such as

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anesthesia units in the operating rooms which, based on your observations, are fixed in place?
A. Not that I know of.
Q. Is there any operating room at the Down East Community Hospital which currently has in it a dental chair and dental delivery unit?
A. Not that I know of.
Q. Do you know if the hospital – strike that. Well, do you know if the hospital has a dental chair and dental delivery unit?
A. No, I don't.
Q. I'm sorry, if there was an answer, I didn't catch it.
A. No, I don't.
Q. Okay. With respect to the operating rooms at the Down East Community Hospital, do you happen to know what the number of air exchanges per hour is in

those rooms?
A. No, I don't have that information either.
MR. KLEIN: Now, Penny?
MS. ST. LOUISE: Yes.
MR. KLEIN: I just want to mark as an exhibit the bill which was provided to me yesterday.
MS. ST. LOUISE: Okay.

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MR. KLEIN: Do you happen to have that?
MS. ST. LOUIS: Yes, we do. It has been marked as Exhibit Number 1.
MR. KLEIN: Okay.
Q. Dr. Verosloff, I would like you, if you could, to take a look at Exhibit 1, which I will state for the record has been provided to me by Attorney St. Louis as a representative bill for dental services which have in the past been provided at Down East. And if I could call your attention to the top of the second page, do you see the notation OR Minor?
A. Yes.
Q. Okay. And what does that refer to, if you know?
A. I don't know. I would only be guessing.
Q. Okay. Can we go off the record for just one second?
A. Okay.
MR. KLEIN: Are we off the record?
MS. ST. LOUIS: Yes.
(Off the record colloquy).
MR. McCARTHY: I don't want to be off the record for these conversations, if nobody minds.
MS. ST. LOUIS: Okay.

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[Page 17]

believe that they are mostly in Africa. We are not real concerned at this point.
Q. Do you know anything about the different infection rates of the different sub types of HIV 1?
A. No, I don't.
Q. Are you – is Down East Community Hospital equipped

to deal with active infective tuberculosis?

A. No, not really. We have been very, as I said before, we have been very lucky and not had to deal with it.

Q. If you do have a case of multi-drug resistant TB, do you refer those patients some place else for care?

A. As of yet we've never had one, but we would send them to Eastern Maine.

Q. Why?

A. One, because we don't have the rooms for it. We don't have the special precautions for it. Two, we are just not – we don't see enough of it to be able to deal with it.

Q. Do you have the engineering controls recommended by the CDC for treatment of TB patients?

A. We try to go by the CDC guidelines. We do not

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have all of the controls in place.

MR. McCARTHY: Just give me a second here.

(Brief pause).

BY MR. McCARTHY:

Q. Does the hospital ever utilize precautions above the bare minimum set by the CDC with respect to infection control?

A. Well, not usually but, you know, we went ahead and used a hepafilter before that was made a CDC requirement, and now it looks like it's not going to be. So in that respect, yes, we are above the CDC, but in most respects, no, we are not. Because we see so little TB, we see so little HIV, we just haven't needed to do it and really haven't.

Q. Are you familiar with the guidelines set by the CDC for the prevention of nosocomial hospital infections?

A. Well, what we do is we have used – go basically by the universal precautions.

Q. Are you familiar with the body substance isolation guidelines?

A. We have protocol for that, and it is used when we feel appropriate. However, a lot of – most of

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the time when we end up with a patient in that sort of condition, they, too, do get sent to the Eastern Maine Medical Center.

Q. What is nosocomial hospital infection?

A. That's one that is transmitted in the hospital usually from patient to patient or doctor to patient, whatever, where it's usually a more virulent, a more – a worse bug, one that is harder to treat, that is more resistant to antibiotics.

Q. Does the hospital always refer such patients because its mandatory, or does the hospital refer such patients to another setting because they think it's more appropriate and just good judgment?

MR. KLEIN: Object to the form. And what such patients are you referring to?

BY MR. McCARTHY:

Q. I don't have to answer his questions. He just makes comments. You still answer.

A. All right, We don't have infectious disease specialists here. So that's one advantage of sending them down. We don't have the isolation rooms yet. We hope to with the special care unit. We don't have that yet. Some hospitals

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makeshift – make negative pressure rooms by putting a fan in the window and turning it backwards. We haven't really tried anything like that. We hope to be able to have a sufficient room with the special care unit.

Q. What is the purpose of negative air pressure in an operating room?

A. Because you want to blow the pathogens, the organisms outside and not contaminate the people inside, the people around. Basically it's for the protection of people.

Q. If any HIV positive patient comes to Down East

Community Hospital for surgery, do you refer that patient to Eastern Maine or some other facility for the reasons you have been describing?

MR. KLEIN: Object to the form.

A. I'm not sure it has happened enough to really tell you. It's like the amount of TB cases, I think we had one over the last two years, and that person was sent to Eastern Maine; one, because you have the pulmonologists there who can do bronchoscopy and get better samples; two, you have the pathologists and the infectious disease people down there. Most of our – I guess our thinking is we feel like a rural hospital, and we ....

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DEFENDANT'S MOTION FOR AN ENLARGEMENT OF TIME WITHIN WHICH TO FILE HIS OPPOSITION TO PLAINTIFF'S MOTION TO EXCLUDE HIS EXPERT TESTIMONY DATED 09/27/95

(Caption omitted in printing)

The defendant, Randon Bragdon, D.M.D., hereby moves for an enlargement of time within which to file his response to plaintiff's motion to exclude him as an expert witness. Dr. Bragdon requests that the time for filing his opposition to that motion be enlarged until ten days following the Court's ruling on the parties' cross motions for summary judgment. This request is consistent with the Court's August 31, 1995, Report of Final Pretrial Conference and Order in which the Court orders that "all filings [including, under Section 3, "objections to the qualifications as to any expert witness], except the consolidated witness list and voir dire, will be due **ten** days following the court's ruling." Report of Final Pretrial Conference and Order at 8. The grounds for Dr. Bragdon's motion are as follows:

1. Dr. Bragdon is not relying upon his testimony as an expert witness on infection control practices or infectious diseases at the summary judgment stage. If, at summary judgment, Dr. Bragdon were submitting an affidavit or relying upon his deposition testimony as an expert on the transmission of infectious diseases at the summary judgment stage, Ms. Abbott is in no way prejudiced by the Court granting Dr. Bragdon's motion for an enlargement of time within which to respond to her motion to exclude him as an expert witness.

2. Dr. Bragdon has the burden of responding within ten days to lengthy motions for summary judgment and legal memoranda (approximately 90 pages) submitted by the United States, Ms. Abbott, and the Maine Human Rights Commission. The additional burden of having to respond to an issue that is irrelevant at this stage in the litigation would significantly impair his ability to respond to the other, important motions. Indeed, if this motion for an enlargement

of time is denied, Dr. Bragdon requests in the alternative an enlargement of time until October 20, 1995, within which to respond to all of the motions filed by the United States, the Maine Human Rights Commission, and Ms. Abbott.

3. Counsel for Ms. Abbott indicate that they oppose Dr. Bragdon's motion for additional time within which to respond to their motion to exclude Dr. Bragdon as an expert witness; but they do not oppose a motion for an enlargement of time within which to respond to all the motions. Dr. Bragdon believes this position is illogical, and prefers to respond to the summary judgment motions as scheduled, and the motion to exclude Dr. Bragdon ten days after the Court's ruling on the summary judgment motions.

WHEREFORE, Dr. Bragdon respectfully requests an enlargement of time until ten days after the Court rules on the parties' cross motions for summary judgment to respond to Ms. Abbott's motion to exclude him as an expert witness on infectious diseases at trial. In the alternative, Dr. Bragdon seeks an enlargement of time until October 20, 1995, within which to respond to the motions filed by Ms. Abbott, the Maine Human Rights Commission, and the United States.

Dated: September 27, 1995

s/ John W. McCarthy,
Esq.

s/Brent A. Singer, Esq.
Rudman & Winchell
Attorneys for Defendant

SUPLEMENTAL AFFIDAVIT OF JOHN A. MOLINARI, PH.D. DATED 10/03/95

(Caption omitted in printing)

I, John A. Molinari, Ph.D., state as follows:

1. I hold a Ph.D. in microbiology from the University of Pittsburgh and am currently a Professor and the Chairman of the Department of Biomedical Sciences at the University of Detroit Mercy School of Dentistry. My career has been focused on studying and teaching about the prevention of transmission of infectious diseases in the dental setting. (Footnote 1: I am co-author of the textbook Practical Infection Control in Dentistry, Lea & Febiger (1991). I have been a consultant to the American Dental Association Council on Dental Therapeutics and the United States Centers for Disease Control and Prevention (CDC) on infection control in dentistry, the development of universal precautions, and the prevention of transmission of bloodborne pathogens including HIV in health care settings. I have also served as President of the Society for Infection Control in Dentistry and the Microbiology and Immunology Group of the American Association for Dental Research. I am on the Editorial Board of the Journal of the American Dental Association and have written and lectured widely on infection control in dentistry and the epidemiology and transmission of HIV. (end of Footnote 1).

2. I have read Defendant Randon Bragdon, D.M.D.'s Rule 19 Statement of Undisputed Material Facts and Defendant's Motion for Summary Judgment. I submit this Supplemental Affidavit to rebut the incomplete and misleading statements in those documents and also to point out that Defendant Bragdon's facts do not support his conclusions about the transmission of HIV in dentistry.

3. Dr. Bragdon cites my testimony for his claim that the risk of transmission of HIV from a patient to a dentist is much greater than the risk of transmission of HIV from dentist to patient. This statement is misleading and does not reflect the full substance of my opinion.

The risk of transmission from dental health care worker to patient and the risk from patient to a dental health care worker are both infinitesimally small. However, if both of these infinitesimally small risks are placed side-by-side, the relative or comparative risk is generally greater for the dental health care worker. But that does not change my opinion that both such risks are so small as to be immeasurable.

4. In his Statement of Undisputed Facts, Defendant Bragdon states that there is "a risk" of transmission of HIV from patient-to-dentist. Defendant Bragdon's apparent basis for this statement is that a dentist can be "exposed" to a patient's blood. (Statement of Facts: Numbers 1, 5, 11, 12, 13). However, these statements do not indicate in any way that such a transmission has ever occurred nor do they indicate the probability of such a transmission occurring in the future.

5. In microbiology and infectious diseases, there is a critical distinction between "exposure" and actual "transmission" of infection. Exposure to blood is not synonymous with infection or the actual transmission of HIV. HIV is a virus of low infectivity which generally cannot be occupationally transmitted without the injection of a large volume of blood into the tissues of a health care worker. Even in the event of an injection of a large volume of HIV-infected blood, transmission rarely occurs due to the low infectivity rate of HIV. In dentistry, any exposure to a patient's blood occurs in such small volumes which have not been shown to result in the transmission of HIV.

6. Because of the low infectivity of HIV, combined with the effectiveness of standard infection control procedures, there has never been a known case of HIV transmission from patient-to-dentist. Thus, while Dr. Bragdon states that there is "a risk" of HIV transmission from patient-to-dentist, that risk has never been demonstrated to have actually occurred. The current data indicate that the risk of such an occurrence in the future is infinitesimally small to negligible.

7. In addition, it is important to keep in mind that the implementation of the standard universal precautions

significantly reduces exposure to a patient's blood in the first place. The recommended universal precautions include barriers such as gloves, gowns, masks and protective eyewear to prevent contact with a patient's blood. The universal precautions also include techniques for the safe handling of needles and sharp instruments which reduce accidental percutaneous injuries. Thus, the universal precautions significantly reduce the already negligible chance of transmission of HIV from patient to dental health care worker.

8. There is no evidence that blood or bloody saliva has ever transmitted HIV in dentistry through the nose, eyes or mouth when a dentist is utilizing barrier protections such as gloves, gowns, masks and protective eyewear. There is no evidence that blood goes up a dentist's nose or into a dentist's mouth during the practice of general dentistry.

9. Moreover, if a dental health care worker has a cut, abrasion or dermatitis on the skin, any risk of HIV transmission can be eliminated by covering the area. For example, a face shield can be worn instead of or in addition to a mask or a small cut can be covered with a band aid. If a cut, scratch or dermatitis is so small as to not be noticed by a health care worker, then a sufficiently large enough volume of blood to transmit HIV could not pass through the skin. A dental health care worker is able to cover all body surfaces which can be exposed to blood splatters during the practice of general dentistry.

10. Dr. Bragdon states that there is a risk of HIV transmission through a needlestick occurring during the injection of a local anesthetic. This has never been demonstrated to have resulted in HIV transmission during dentistry. This is due, at least in part, to the extremely small amount of blood which a dentist would be exposed to from such an accident. The needle used to inject local anesthetic has a very small opening at its tip which will not hold a large volume of blood (compared, for example, to a needle used to draw a blood sample from a patient). In addition, the anesthetic is never injected near an artery or other significant blood source. Thus, if a dentist is accidentally stuck with a needle, the dentist will be exposed only to a very small amount

of the patient's blood. The small volume of blood is further reduced because some of it is wiped off when the needle passes through the latex glove.

11. Dr. Bragdon can virtually eliminate the occurrence of an accidental needlestick by following the currently recommended procedure for the injection of a local anesthetic. According to Dr. Bragdon's Statement of Facts, his practice is to place his fingers in the patient's mouth next to the needle while he injects the anesthetic. The currently recommended procedure involves removing one's hand from the injection site, retracting the cheek with a mirror, and injecting the anesthetic with the other hand. This method virtually eliminates any risk that a dentist will be stuck with a needle during the injection of a local anesthetic. Other types of injuries in dentistry with solid or sharp instruments are not inevitable, buy may occur. However, these solid instruments transfer even less blood than needles used for local anesthesia and have never been shown to transmit a virus of such low infectivity as HIV.

12. It is true that three to four percent of persons with AIDS have not disclosed identifiable behavioral risk factors for HIV infection. However, this statistic does not at all illuminate[sic] the probability of HIV transmission from patient to dental health care worker. There is no scientific or epidemiological basis to make the leap that any of these individuals occupationally contracted HIV. In addition, there is no evidence as to how many, if any, such persons are dental health care workers.

13. HIV is not an airborne pathogen and there is no evidence that HIV can be transmitted through the air. A special respirator mask which filters airborne pathogens is not helpful in reducing the transmission of HIV.

14. There is no evidence of patient-to-patient transmission of HIV in dentistry. If a dentist follows CDC recommendations to heat sterilize instruments between patients, as I am informed that Dr. Bragdon does, there is no risk of HIV transmission from patient-to-patient in dentistry. Heat sterilization, by definition, kills all microorganisms on

dental instruments, including HIV.

Dr. Bragdon cites as Exhibit 7 of his Motion an article in Nature magazine to support his statement that HIV can be transmitted from one patient to another patient in the dental office. Dr. Bragdon's use of the Nature article is inaccurate and grossly misleading. The article unequivocally states:

> Adherence to CDC heat-sterilization standards virtually eliminates risks of blood-borne disease transmission by reused dental devices. (p. 956).

The part of the article which Dr. Bragdon quotes in his Motion (p. 23) indicates only that the researcher isolated HIV entrapped in instruments which had not been heat sterilized, but which instead had been soaked in a disinfectant.

15. There is no evidence that HIV can be transmitted by bloody saliva that is retracted into the dental water unit lines. The standard procedure in dentistry is to flush the water lines between patient uses. No one has ever recovered live HIV in flushed dental water unit lines nor is there any evidence that HIV can survive in water. In addition, it is recommended that dentists use anti-retraction valves which prevent water or bloody saliva in a patient's mouth from being retracted into the water lines.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Dated: 10-3-95 /s/ John A. Molinari, Ph.D.

SUPPLEMENTAL AFFIDAVIT OF DONALD E. CRAVEN, M.D. (CAPTION OMITTED IN PRINTING)

I, Donald E. Craven, M.D., state as follows:

1. The health care profession necessarily and unavoidably involves exposure to patients with infectious diseases. Therefore, when a person chooses to work in health care, including medicine and dentistry, he or she accepts the reality of exposure to infectious diseases.

2. Because many patients with infectious diseases, including HIV, may be asymptomatic and have not been identified, a health care worker cannot avoid exposure to infectious microorganisms, including viruses and bacteria. Exposure to patients with such infectious diseases occurs in every health care setting – including a hospital and a private medical or dental office.

3. In his Motion at pp. 24-25, Dr. Bragdon misquotes my testimony. My opinion that a health care worker should treat patients with HIV is premised on my opinion that the risk of infection to the health care worker is infinitesimally small, less than the risk of death involved in driving a car or being struck by lightning. Moreover, since many people with infectious diseases are asymptomatic and are not detected, health care workers face some risk in the performance of their professional obligations, even though it is negligible.

4. A woman with HIV disease has a significant risk of transmitting HIV to a newborn. HIV-positivity substantially affects and limits an HIV-positive woman's decision and ability to procreate safely.

5. During my deposition in this case, I was not asked how HIV-positivity affects or limits procreation. If I had been asked that question, I would have provided my opinion as stated in paragraph four above.

I DECLARE UNDER PENALTY OF PERJURY

THAT THE FOREGOING IS TRUE AND CORRECT.

Dated: 10/4/95 s/Donald E. Craven, M.D.

DECLARATION OF DONALD WAYNE MARIANOS, D.D.S., M.P.H. DATED 10/06/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.S., M.P.H. declare that:

I have read Defendant Bragdon, D.M.D.'s Rule 19 Statement of Undisputed Material Facts and Defendant's Motion for summary Judgment. Based upon my education, experience and expertise I offer the following opinions in this case:

1. I am the Director of the Division of Oral Health at the Centers for Disease Control and Prevention ("CDC"). It is the position of the CDC that when universal precautions are used, persons with HIV or AIDS or other blood-borne pathogens can be safely treated in private dental offices.

2. Dr. Bragdon uses the example of the administration of a local anesthetic as a means by which he could acquire HIV occupationally. The risk of exposure by this method can be reduced by using instruments instead of fingers to retract tissue or guide anesthetic needles during injections. In a recent CDC observational study of general dentistry and oral surgery residents in New York City, no injuries were reported during the administration of over 16,000 anesthetic injections by residents who were taught this preventive technique (Cleveland, JADA 1995). In addition, self-sheathing anesthetic syringes are now available to prevent needlestick injuries during or after anesthetic injections.

3. No scientific data is available to support the hypotheses that aerosolized particles containing infective HIV may be produced in dental or medical settings or that HIV may be transmitted by aerosols by the respiratory route (Short 1993). Thus, use of a particulate respirator is completely unjustifiable to prevent transmission of HIV in any health-care setting, including dental settings.

4. The risk of acquiring HIV following a mucous membrane exposure (0.09%) or skin exposure (<0.04%) to HIV infected blood is much less than the risk following a percutaneous exposure (0.3%). These risk estimates are for contacts with blood and would likely be much lower for blood contaminated saliva. Use of gloves, masks (standard surgical) and eyeglasses, or faceshields, as required by universal precautions, can easily protect the dental worker from skin and mucous membrane exposures to blood or saliva contaminated with blood. Additional precautions for dentistry include the use of rubber dams, high-speed suction, and proper patient positioning. CDC guidelines also recommend that dental workers with open sores, oozing dermatitis, or other similar lesions avoid patient contact until the skin has healed.

5. Studies of injuries among dentists indicate that the number of sharps injuries reported by dentists have decreased from about 12 injuries per year in 1987 to the current rate of 3-4 injuries per year (Cleveland, Infect Control Hosp Epidemiol 1995).

6. Studies also have found that injury rates among dental workers are probably less than among general surgical personnel. Data from CDC's observational study among general dentistry and oral surgery residents found that dental residents experienced about 2 injuries per 1000 hours of observation, a much lower rate of percutaneous injuries than general surgery personnel who, in another CDC study, experienced 34 injuries per 1000 hours of observation.

7. Infection control recommendations to prevent the retraction of patient material into dental unit water lines have been addressed in CDC guidelines since 1986. These recommendations should be followed in all health-care settings where dental treatment is provided (including private dental offices and hospital dental settings).

8. The CDC has established a hierarchy of exposure categories (or "identifiable risk factors") for HIV. The hierarchy of exposures include: men who have sex with men; injecting drug use; men who have sex with men and inject

drugs; heterosexual contact (with infected individuals); hemophilia/coagulation disorder or receipt of blood transfusion, blood components, or tissue.

9. "No risk reported or identified" cases involve persons with no reported history of exposure through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was unavailable and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

10. At any given time, there will be a number of cases with no identified risk. Among those, the majority will fall into the category described above as "currently under investigation." The follow-up investigation for a majority of these cases will reveal an identified risk factor (within the hierarchy of risk factors), and the case will be appropriately reclassified.

11. The vast majority of health care workers with AIDS have reported nonoccupational risk factors for HIV infection. Studies have revealed that, since 1987, a higher proportion of health care workers compared with other persons with AIDS, 6% vs. 3%, have been classified in the undetermined risk category. However, it is likely that a number of these health care workers had nonoccupational risk factors that they did not report or recognize (e.g., sexual contact with a partner suspected or known to be infected).

12. There is no scientific evidence whatsoever to support Dr. Bragdon's statement at pp. 13-14 of his brief, that transmissions of HIV by "a drop of blood going up the nose of the dentist, or a drop of blood landing on a cut or scratch on his body of which he was aware. . .may be occurring with "alarming frequency," but have not been documented. If in fact, transmissions of HIV from infected patients to dentists

were occurring with "alarming frequency", one would expect a high rate of previously undetected HIV infection among the over 6,000 dentists who have participated in seroprevalence studies conducted at annual meetings of the American Dental Association. However, these studies continue to indicate very low HIV-seroprevalence (Gruninger 1991, Siew 1994).

13. The CDC identifies "possible" cases of occupational transmission in the health care setting as those in which "health care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids. . .but HIV seroconversion specifically resulting from an occupational exposure was not documented."

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
October 6, 1995

s/Dr. Donald Wayne Marianos
Dr. Donald Wayne Marianos
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SUPPLEMENTAL DECLARATION OF DEBORAH GREENSPAN, BDS, DSc, ScD(hc), FDS, RCSFd(Hon) DATED 10/5/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Deborah Greenspan, BDS, DSc, ScD(hc), FDS RCSEd(hon) declare that:

I have read Defendant's Motion for Summary Judgment in his above-referenced matter. Based on my education, experience and expertise I offer the following additional opinions in this case:

1. I am currently Clinical Professor of Oral Medicine at the University of California at San Francisco and am also Chair of the Compliance Committee on Infection Control at the UCSF School of Dentistry. I have treated over one thousand patients who are HIV-positive. In addition, I have supervised many dental students and residents who routinely treat HIV-positive patients in the dental clinic and use the same infection control procedures as can and should be used in a private dental office. It is my opinion that HIV-positive patients may be safely treated in a private dental office when universal precautions are used.

2. The proper way to reduce the transmission of infectious diseases is not to refuse to treat those who actually acknowledge harboring such diseases, but rather, to treat all persons as if they are potentially infectious. Many persons who are infectious for HIV, Hepatitis B, and other bloodborne pathogens do not know that they are infected, and many of those who do know their infectious status may choose not to inform their health care providers of this fact.

3. If a health care worker such as Dr. Bragdon believes that he is eliminating the risk of occupationally acquiring an infectious disease by refusing to treat those who acknowledge their infectious status, he may actually be creating a more risky environment for himself, his staff, and his other patients. By believing he has eliminated a risk,

where, in actuality, he has not, he may become less stringent in his practice of infection control.. If, on the other hand, Dr. Bragdon treats all patients as potentially infectious, regardless of what they know or choose to disclose, then Dr. Bragdon will use the highest infection control procedures at all times, and will be operating in an environment in which the risk of transmission of HIV and other bloodborne pathogens is almost negligible.

4. Those of us who work in health care, and in dentistry in particular, do not expect to work in a risk free environment. Just as a firefighter expects to be exposed to fires, health care workers expect to be exposed to people who are sick, including those who harbor infectious diseases.

5. At the time Dr. Bragdon started practicing, it was common knowledge that Hepatitis B posed a significant occupational risk to dental health care workers. Hepatitis B is a highly infectious virus. Approximately 200 health care workers die from Hepatitis B infection on a yearly basis, and countless more suffer permanent and debilitating Hepatitis B-related conditions.

6. As a dentist, I believe that the ethical duties of our profession oblige us to help those in need, including those with HIV/AIDS. I believe that it is unethical to deny care to a patient because you are afraid of treating that patient, especially, where, as here, one's fears are not grounded in science.

7. In his affidavit, Dr. Bragdon describes the method by which he administers a local anesthetic before filling a cavity on a back, lower tooth, such as Mr. Abbott's. Current recommendations include retracting (pulling back the lip and cheek) with a mirror rather than one's fingers, so that an accidental injury of the type described by Dr. Bragdon could not happen. This method is easy to perform and greatly reduces the chance of accidental injury.

8. In his brief, Dr. Bragdon alleges that the filling of a cavity creates an "obvious" risk of transmission of HIV from patient to dentist, and that intraoral injuries (i.e., those

occurring inside the patient's mouth) are "inevitable" in the dental setting. These allegations are not supported by current science. Rather, recent studies demonstrate that, on average, dentists only incur three to four percutaneous injuries per year, of which the majority occur outside the patient's mouth. Moreover, in approximately 99.7% of the cases in which a health care worker suffers a percutaneous injury from a needlestick that is actually contaminated with HIV-infected blood, the health care worker will not acquire HIV. The chance of acquiring HIV from any other type of sharps injury is significantly less. Most importantly, there has never been a documented case of HIV transmission from patient to dental health care worker.

9. In his brief, Dr. Bragdon describes hypothetical means by which a dentist or his assistant could contract HIV while treating a patient. These are all based on conjecture and speculation, with no support in science. There is no evidence whatsoever that HIV can be transmitted via aerosolization. Similarly, there is no evidence that HIV can be transmitted through the nose or the mouth or through defects in the dental mask. If a dental health care worker has dermatitis on an ear, or a scratch or an abrasion that is not already covered by her gloves, gown, and protective face covering, the dental health care worker should cover the exposed skin (e.g., with a bandaid) before treating any patient. In addition, regardless of whether a dental health care worker's gloves are visibly contaminated with blood, he or she must remove those gloves before touching any part of his or her body. If the cut or abrasion is so insignificant as to not be noticed by the dental health care worker, then it is almost impossible for a sufficient amount of HIV-contaminated blood to enter the dental health care worker's bloodstream via the cut. There must be a significant cut or scratch and a significant amount of blood for the dental health care worker to acquire HIV occupationally.

10. HIV is not an airborne pathogen. No public health, scientific, medical, or dental organization has ever recommended that a dentist wear a respirator when treating an HIV-positive patient.

I hereby declare under penalty of perjury that the

foregoing information is true to the best of my knowledge and belief.

Executed on
October 5, 1995

s/Deborah Greenspan
Dr. Deborah Greenspan
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DECLARATION OF DONALD WAYNE MARIANOS D.D.S., M.P.H. DATED 10/18/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I, Donald Wayne Marianos, D.D.S., M.P.H., declare that:

I have read Defendant's Memorandum of Law in Opposition to Plaintiff's Motion for Summary Judgment, and the Second Declaration of Sanford F. Kuvin, M.D. Based upon my education, experience and expertise I offer the following additional opinions in this case:

1. While statistical modeling, such as that employed by Dr. Kuvin, may be useful in estimating orders of magnitude of the risk of HIV transmission from an HIV-infected patient to dentist, these models are based on a multitude of assumptions. Estimates derived from theoretical modeling can only be as accurate as the sum of the modol's individual elements.

2. Dr. Kuvin uses an estimate of 1.5 needlestick injuries per 100 injections given by dentists. In a more recent study (Cleveland, JADA 1995) in which dentists were observed for 6 months, zero injuries were recorded during over 16,000 injections. Siew's prospective "Diary" study (JADA 1995) found an annualized mean injury rate of about one needlestick every two years.

3. Dr. Kuvin uses the estimate that 3 out of 1000 accidental needlesticks from HIV-contaminated needles will result in occupational acquisition of HIV. While this is an accurate statistic, it represents the risk to all health care workers generally, not dentists specifically. The risk of HIV transmission following a percutaneous exposure to HIV infected blood is likely to depend on several factors, including the size of inoculum (i.e., the amount of blood injected). Because the size of anesthetic needles used in dentistry is much smaller than that used in most medical settings, the

majority of needlesticks among dental workers will involve smaller, rather than larger amounts of HIV infected blood. It is the position of the CDC that the risk of acquiring HIV occupationally from a needlestick in the dental setting is so low that it cannot be accurately quantified.

4. Dr. Kuvin also uses the assumption that 1 out of 3 needlestick injuries to dentists results in parenteral exposure to patient blood. I am unaware of any study supporting this assumption.

5. Dr. Kuvin is incorrect when he states "1/3 of all reported exposures for dental workers have HIV, and no other identifiable risk factors except for occupational exposures." Dr. Kuvin has confused CDC's prospective needlestick study (described in the Gooch article attached to Dr. Kuvin's affidavit) and CDC's surveillance system for HIV/AIDS. The nineteen dental workers described in the Gooch article were voluntarily enrolled in a national prospective study of health care workers exposed to HIV infected blood. To our knowledge, none of these exposures resulted in HIV transmission to an enrolled dental worker.

This study is completely separate from the CDC's ongoing surveillance system, in which six dental workers with AIDS have been identified as having no identifiable risk factors other than percutaneous or mucocutaneous exposure to blood. As noted in my previous affidavit, it is likely that a number of health care workers identified as having no identifiable risk factors actually had nonoccupational risk factors that either they or their proxies did not report or recognize.

6. Evaluating the risk of HIV transmission in dental settings has included data from CDC's surveillance activities of health-care workers, HIV seroprevalence studies conducted by the American Dental Association among dental workers' prospective studies that evaluate the risk of seroconverting following an exposure to HIV-infected blood (CDC Needlestick study), and studies that attempt to define the frequency and circumstances of blood contacts in dental settings.

7. As of 1993, approximately 86% of currently practicing U.S. dentists had received the hepatitis B vaccination. A recent study suggests that the vaccination will only be effective in 88% of the dentists who receive the three doses of the vaccination. Dentists under the age of 45 years were 2.5 times more likely than dentists greater than 45 years to be vaccine responders.

8. Dr. Kuvin suggests that the practice of dentistry involves greater exposure to blood than the practice of most surgeons. I know of no study which supports this suggestion.

9. There is a difference bewteen "being at high risk for TB infection" and "being at high risk for progression from latent TB infection to active disease." Dr. Kuvn inaccurately conflates these risks.

10. Epidemiologic studies do not indicate that persons with HIV/AIDS are at increased risk for TB infection. The majority of persons in the United States infected with HIV are not infected with TB, and the majority of persons in the United States infected with TB do not have HIV/AIDS. Groups of persons known to have a higher prevalence of TB infection include the elderly, foreign-born persons from areas of the world with a high prevalence of TB (e.g., Asia, Africa, the Caribbean, and Latin America), medically underserved populations, homeless persons, alcoholics, injecting-drug users, and residents and employees of high-risk congregate settings (e.g., correctional institutions, nursing homes, and mental health institutions.

11. Persons with HIV/AIDS are at high risk for progression from latent TB infection to active disease. In other words, if persons with HIV/AIDS are exposed to the TB bacillus and become infected, they are at greater risk than members of the general population for progressing from latent (inactive) TB infection to active TB disease. Other groups at higher risk for progression from latent TB infection to active disease include persons who have been infected with TB recently (i.e., within the previous 2 years), children less than four years of age, and persons with certain medical conditions

(e.g., chronic renal failure with renal dialysis, diabetes mellitus, and immunosuppression from chemotherapy).

12. The CDC recommends that all persons referenced in paragraphs 10 and 11 receive a PPD-tuberculin skin test on a yearly basis.

13. The CDC has never stated that all persons with HIV should be referred to an appropriately TB-engineered facility for dental treatment.

14. Current CDC guidelines state that patients suspected of having undiagnosed active TB should be referred to a physician for medical evaluation. Suspicion of TB should be based on a patient's medical history (i.e., whether they have a history of TB disease) and whether they have symptoms suggestive of TB (cough, night sweats, bloody sputum, anorexia, and fever), not solely or a patient's HIV status. If the patient is diagnosed by his or her physician as having active TB, dental treatment should be deferred until the patient no longer is infectious. Only if a patient requires emergency dental care should he or she be treated in a facility that can provide TB isolation.

15. If Dr. Bragdon wishes to screen out all persons from his dental practice who are "at risk" for TB, he should screen out not only persons with HIV/AIDS, but all persons who the CDC considers to be "at risk," including the elderly, persons with cancer who are immunocompromised, and residents of mental health institutions. Based on information provided to me, it is my understanding that Dr. Bragdon provides dental treatment to these patient populations and does not refer them to appropriately TB-engineered facilities.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
October 18, 1995 s/Donald Wayne Marianos
Dr. Donald Wayne Marianos

Centers

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FOURTH DECLARATION OF
OF DONALD WAYNE MARIANOS, D.D.S., M.P.H.

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.S., M.P.H. declare that:

I am a Captain in the United States Public Health Service ("USPHS") at the Centers for Disease Control and Prevention ("CDC"), and am the Director of the Oral Health Program. I am testifying in this case in my official capacity. My testimony in this declaration, as in my prior declarations, is on behalf of and represents the views of the CDC.

I have read, and am familiar with, the articles cited in Defendant's Rule 60 Motion for Relief from Order and Incorporated Memorandum of Law. The majority of these articles were published in the early 1990's, and my prior testimony took into account the results of the studies reported in those articles. Nothing published since October 18, 1995 (the date of my last declaration) would cause me to alter, in any way, my prior testimony to this Court.

1. It remains the view of the CDC that it is safe to provide routine dental care to patients with HIV and AIDS in private dental offices when universal precautions are utilized.

2. It remains the view of the CDC that the provision of routine dental care to persons with HIV or AIDS requires no additional procedures beyond the CDC recommendations.

3. It remains the view of the CDC that the risk of HIV-transmission in the health care setting is very low; that, in a dental setting, the risk of HIV transmission from patient to provider is so low as to be unquantifiable; and that, when implemented, the CDC recommendations reduce the already low risk of disease transmission in the dental environment, from either patient to dental health care worker, dental health care worker to patient, or patient to patient.

4. It remains the view of the CDC that it is safe to provide dental care to patients with AIDS, including those who are in the final stages of AIDS, in private dental offices when universal precautions are utilized. The MMWR report of December 22, 1995 (Exhibit 9 to Defendant's Rule 60(b) Motion) does not suggest otherwise. The MMWR report provides additional evidence corroborating the low risk of HIV transmission in the health care setting, and further supports our conclusion that the risk of transmission in dentistry is very low. Assuming this very low risk, the MMWR study further breaks down the factors identified with transmission. One of these factors is the stage of disease, because there is a direct relationship between the stage of disease and the viral titer (number of pathogens in an infected individual). But the viral titer is only one component of the multifactorial chain of disease transmission. The efficacy of universal precautions is in no way affected by the stage of the patient's disease. The MMWR study's identification of this factor in no way challenges the CDC's conclusion that people in the final stages of AIDS can be safely treated in a private dental office so long as universal precautions are utilized.

5. The Hepatitis studies referred to in Bragdon's Rule 60 motion must be placed in proper perspective. Hepatitis is 100 times more infective than HIV. The studies refer to thoracic surgery and cardiac surgery, which the articles themselves describe as highly invasive and of long duration. Yet, since 1987, when dentists routinely began to use universal precautions, there has not been one documented case of Hepatitis transmission in dentistry. And, as I testified previously, there has never been a documented case of HIV transmission from patient to dentist, or from infected patient to non-infected patient, in the dental health care setting.

6. It is the position of the CDC, the Association of State and Territorial Health Officials, the Association of State and Territorial Dental Directors, and other recognized public health organizations of which I, personally, am aware that universal precautions are an effective form of infection control, and that it is safe to treat individuals with HIV and AIDS in a private dental setting.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
April 1, 1996

s/Donald Wayne Marianos
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FINAL JUDGMENT
DATED APRIL 22, 1996

[U. S. DISTRICT COURT
DISTRICT OF MAINE]

[ABBOTT V. BRAGDON]

[Caption omitted in printing]

The Court having ruled on all pending claims and motions in its Orders dated December 22, 1995, and April 22, 1996, judgment shall enter in the above-captioned matter in favor of Plaintiffs against the Defendant.

Dated at Bangor, Maine, on April 22, 1996

/s/Morton A. Brody, United States District Judge

JUDGMENT

[UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT]

Entered March 5, 1997

[ABBOTT V. BRAGDON]

[Caption omitted in printing]

This cause came on to be heard on appeal from the United States District Court for the District of Maine, and was argued by counsel.

Upon consideration whereof, it is now here ordered, adjudged and decreed as follows: The judgment of the District Court is affirmed.

By the Court
/s/ William H. Ng, Clerk

WEDNESDAY, NOVEMBER 26, 1997

CERTIORARI GRANTED

97-156 BRAGDON, RANDON V. ABBOTT, SIDNEY, ET AL.

The petition for a writ of certiorari is granted limited to Questions 1, 2, and 3 presented by the petition. The brief of petitioner is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, January 9, 1998. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, February 6, 1998. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, March 6, 1998. Rule 29.2 does not apply.